Presented by Provider Relations & Education

Note: Contents are subject to change and are not a guarantee of payment.
• Welcome & Introductions
• Quality Initiatives
• Federal Employee Program (FEP)
• State Health Plan (SHP)
• Preferred Blue® (PPO)
• BlueChoice® HealthPlan of South Carolina
• Medicare Advantage
• New Groups

• BlueChoice HealthPlan Medicaid
• Mental Health
• Prescription Monitoring Program
• Pharmacy Management
• Electronic Data Interchange (EDI)/ICD-10
• BlueCard® Program
• Ancillary Claims
• Web Tools
• National Imaging Associates (NIA) & Radiation Oncology Program
• Additional Provider Updates
• Affordable Care Act (ACA)
• Health Insurance Marketplace (Exchanges)
• Closing

NIA is an independent company that provides utilization management services on behalf of BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina.
To serve as liaisons between BlueCross BlueShield of South Carolina, BlueChoice® and the health care community to promote positive relationships through continued education and problem resolution.
Provider Advocate Service Area

Provider Education Territory Map

Education and Outreach
Teosha Harrison, Manager
Shamia Gadsden Quality Education
Contessa Struckman, Ancillary and Quality Education
Sharman Williams, BlueCard Education
Elizabeth Duvall, Internal Education
Bunny Thomas, Internal Education

Contact Information
Phone: 803.264.4730
Fax: 803.264.8851
Email: provider.education@bcbssc.com

Provider Advocates
Mary Ann Shipley
Ashlie Graves
Jada Addison
Sandy Sullivan
Our department of internal and external provider advocates provides educational support for these lines of business:

- SHP
- FEP
- Medicare Advantage
- Dental
- BlueCross
- BlueChoice
- BlueChoice HealthPlan Medicaid

- Health Insurance Marketplace (Exchanges)
- Planned Administrators Inc. (PAI)
- Thomas Cooper & Company (TCC)

PAI and TCC are separate companies that provides third party administration services on behalf of BlueCross.
How We Support You

- **Webinars:** We offer online presentations of various education topics each month.

- **Newsletters and Bulletins:** BlueNews℠ for Providers is available monthly and we post provider updates in the Provider News section of both websites.

- **Regional Workshops:** Workshops on corporate initiatives are presented throughout the year.

- **Direct Contact and Support:** You can reach our internal and external advocates by calling 803-264-4730 or by email at Provider.Education@bcbssc.com.

- **Reports:** Monthly, and upon request, providers receive Gaps in Care (GIC) reports, Provider Report Cards and even pending claim reports.

- **On-site Visits:** Upon request we will visit your office to train your staff on our business processes.
Quality Initiatives
presented by Shamia Gadsden
Maternity Initiatives

As part of our partnership with the South Carolina Department of Health and Human Services (SCDHHS), we implemented new programs to improve birth outcomes for infants:

- Birth Outcomes Initiatives (BOI)
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Centering Pregnancy
In July 2011, the SCDHHS began partnering with organizations to improve the health of newborns in South Carolina. This effort is known as the BOI. The BOI focuses on achieving five key goals:

1. Ending elective inductions for non-medically indicated deliveries prior to 39 weeks. This also helps reduce the number of cesarean sections as well as neonatal intensive care unit (NICU) admissions.

2. Reducing the average length of stay in NICUs and pediatric intensive care units.

3. Making 17P, a compound that helps prevent pre-term births, available to all at-risk pregnant women with no “hassle factor.”

4. Implementing a universal screening and referral tool for physicians. This tool will screen pregnant women for tobacco use, substance abuse, depression and domestic violence.
Maternity Initiatives Participation

BOI filing requirements apply to all BlueCross and BlueChoice plans as well as out-of-state (BlueCard) members.

Currently, SBIRT and Centering initiatives apply to all South Carolina BlueCross and BlueChoice plans, except:

- FEP
- Out-of-state members (BlueCard)
- State Children’s Health Insurance Program (CHIP)
- Plans that do not have maternity benefits
- National accounts

Effective October 1, 2014, the SHP began participating with SBIRT and the Centering Pregnancy program.
CAHPS Survey

CAHPS is a survey that supports consumers in assessing the performance of their health plans and choosing a plan that best fits them.

- Asks consumers and patients to report on and evaluate their experiences with health care services.
- Covers topics that are important to consumers and focuses on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.
CAHPS Survey

- Measures a member’s satisfaction with the health plan, providers, availability of services, customer service and access to care.
HEDIS is a tool used to measure performance in the delivery of medical care and preventive health services.

- The National Committee for Quality Assurance (NCQA) coordinates and administers yearly.
- HEDIS is used by more than 90 percent of American health plans.
- HEDIS covers 80 measures across five domains of care.
- HEDIS evaluates both physical and behavioral health clinical practice guideline (CPG) adherence.
CAHPS and HEDIS

How do CAHPS and HEDIS affect your practice?

• Evaluate the quality of care you provide to our members through HEDIS and CAHPS results

• Identify areas of excellence and opportunities for improvement

• Submit medical records
CAHPS and HEDIS

How are members selected for review?

**HEDIS:**

- **Annually** — Members are randomly selected for review based on a predetermined sample size, which is identified for each measure. This takes place during the annual data collection project, which is performed each spring.

- **Year-round** — Members who have not had a claim submitted for specific services may be selected to assess barriers and provide information to providers. (Gaps in Care Report)

**CAHPS:**

- **Annually** — Members are randomly selected for review. This takes place each spring.
HEDIS

This performance tool helps plans:

- Measure overall performance for the medical care provided in a plan’s service area.
- Identify areas for improvement.
- Develop quality initiatives.
- Provide educational programs for providers and members.

The measures are developed around conditions or services that impact a large portion of the population.

Data is collected through retrospective review of services via claims information and medical records.

We are less likely to request medical records when you submit claims with all appropriate procedure and diagnosis codes.
Mid-October 2014
Supplemental Review Process Begins

Mid-January 2015
Hybrid Medical Records Review Process Begins

Early January 2015
Quality Nurses Onsite Scheduling Begins

March 2015
Supplemental Review Process Ends

May 2015
Hybrid Medical Record Review Process Ends

June 2015
Final Rates are Submitted and Locked
How does South Carolina rank?

• Ranked 43rd in the nation overall for “healthiest states” – in part because of the state’s effort to ensure poor children get Medicaid

• Ranked 44th in the nation in prevalence of diabetes (One of the highest rates of diabetes at 11.6 percent of our adult population – over 400,000 people have diabetes)

• Ranked 44th overall in obesity

• Ranked 38th in the nation in smoking prevalence

• Ranked 47th in the nation for adolescents ages 13-17 for immunizations

• Ranked 17th in the nation for children ages 19-35 months for immunizations

• Ranked 3rd for DUI fatalities

December 2013 edition of America’s Health Rankings & United Health Foundation
How does South Carolina rank?

- Ranked 1\textsuperscript{st} for domestic violence
- Ranked 2\textsuperscript{nd} for violent deaths of women
You will receive GIC provider report/s from your provider advocate and support in understanding this quality initiative.

Your physician or practice can gain recognition for promoting good health and fighting disease.

Our QI nurses will meet with you for “deep dive” chart reviews and techniques to closing care gaps.
GIC Provider Report

The Provider Summary Report shows:

• The number of members assigned to each measure
• The number of members compliant within each measure
• The provider’s rating for each measure
• The Star benchmarks for each measure
The Provider Detail Report includes those members with gaps in care and shows:

- ID Card Number
- Date of Birth
- Gender
- Quality Measure (undocumented or reported gap)
Closing Gaps in Care

The HEDIS Provider Reference Matrix provides measure-specific information and how you can help close gaps in care.

You may have relevant information indicating the member has already received the service or has a condition that excludes him or her from the measure. When this is the case, you can close the gap by:

• Submitting a claim for the service.
• Submitting the medical record.
• Submitting the appropriate Compliance Companion Form.
Closing Gaps in Care

If we need medical documentation, you can submit a Compliance Companion Form in place of medical records.

A doctor or nurse practitioner’s signature is required.

You can find these forms at www.SouthCarolinaBlues.com or www.BlueChoiceSC.com.
Closing Gaps in Care

Medical record review examples of core documentation standards:

- Patient demographic data present in chart
- Medication allergies and adverse reactions
- Annual discussion of advance directives for ages 21 and older
- Current medication and problem list
- Past medical, surgical and immunization history
- Documentation for each visit: clinical findings/appropriate treatment
- Remember to calculate and file the appropriate Body Mass Index (BMI) diagnosis code
Closing Gaps in Care

You may receive medical records requests from us in order to close gaps in care.

We do not pay fees for supplying medical records. Please send the requested record so we can verify your patients’ compliance.

Let your medical records vendor know that release of records is a “no charge event.”
Patient-Centered Medical Home (PCMH) 
presented by Shamia Gadsden
A PCMH is a team-based approach to health care led by a physician, nurse practitioner or physician assistant. It is a primary care practice that addresses all of a patient’s health care, either directly or by coordinating care in a team approach with specialists. It also has national certification as a PCMH.
BlueChoice Announces New Product For PCMH

• BlueChoice is offering a new product called Engagement Plus that combines incentives for employees who use PCMH and wellness tools the workplace provides.

• The Engagement Plus plan offers the highest level of benefits when a member uses a PCMH, especially those who have high blood pressure, heart failure or diabetes. It is available to companies with 100 or more employees.
Federal Employee Program
presented by Jada Addison
The www.FEPBlue.org website has a brand new look! Here you can find specific information about policies, procedures, membership or claims data. You can also contact the FEP area directly by calling 888-930-2345.
## Standard Option

<table>
<thead>
<tr>
<th>Benefits</th>
<th>2014 Benefit</th>
<th>2015 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEDUCTIBLES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$350</td>
<td>Same as 2014</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$700</td>
<td></td>
</tr>
<tr>
<td><strong>SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>$20 Primary Care Physician (PCP) Copayment $30 Specialist Copayment</td>
<td>Same as 2014</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>15% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>15% Coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>CATASTROPHIC MAXIMUM</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual-Network</td>
<td>$5,000</td>
<td></td>
</tr>
<tr>
<td>Family-Network</td>
<td>$6,000</td>
<td></td>
</tr>
<tr>
<td>Individual-Out of network</td>
<td>$7,000</td>
<td></td>
</tr>
<tr>
<td>Family-Out of network</td>
<td>$8,000</td>
<td></td>
</tr>
</tbody>
</table>
### 2015 FEP Standard Option Updates

<table>
<thead>
<tr>
<th>Services</th>
<th>2014 Benefit</th>
<th>2015 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient mental health and substance abuse (MHSA)</td>
<td>Non-participating provider services subject to calendar year deductible.</td>
<td>Not subject to calendar year deductible when performed by a non-participating provider</td>
</tr>
<tr>
<td>professional visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient MHSA admissions at residential treatment</td>
<td>Residential treatment centers are not covered.</td>
<td>Allowed for members with Medicare Part A as their primary coverage</td>
</tr>
<tr>
<td>facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient MHSA services at a non-member facility</td>
<td>Subject to a $350 per admission copayment for unlimited days plus 35% of plan allowance and any remaining balance</td>
<td>Member pays 35% of the plan allowance for unlimited days and any remaining balance after our payment</td>
</tr>
<tr>
<td>Medical emergency in preferred urgent care facility</td>
<td>$40 copay per visit</td>
<td>$30 copay per visit</td>
</tr>
</tbody>
</table>
## Basic Option

<table>
<thead>
<tr>
<th>Benefits</th>
<th>2014 Benefit</th>
<th>2015 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEDUCTIBLES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$0</td>
<td>Same as 2014</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>$25 PCP Copayment $35 Specialist Copayment</td>
<td>Same as 2014</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>$100 Copayment</td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$125 Copayment</td>
<td></td>
</tr>
<tr>
<td><strong>CATASTROPHIC MAXIMUM</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual-Network</td>
<td>$5,500</td>
<td></td>
</tr>
<tr>
<td>Family-Network</td>
<td>$7,000</td>
<td></td>
</tr>
<tr>
<td>Individual-Out of network</td>
<td>No coverage out of network</td>
<td></td>
</tr>
<tr>
<td>Family-Out of network</td>
<td>No coverage out of network</td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td>2014 Benefit</td>
<td>2015 Benefit</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cardiovascular monitoring services, other than basic electrocardiograms (EKGs)</td>
<td>Not subject to a copayment</td>
<td>Copay is $40 when performed by preferred professional and facility providers</td>
</tr>
<tr>
<td>Accidental injury or medical emergency in preferred urgent care facility</td>
<td>Subject to a $50 copay per visit</td>
<td>Subject to a $35 copay per visit</td>
</tr>
</tbody>
</table>
## Residential Treatment Centers

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient MHSA</td>
<td>A residential treatment center is a covered facility.</td>
</tr>
<tr>
<td>Inpatient MHSA services provided at</td>
<td>For a residential treatment center, we cover ancillary services or</td>
</tr>
<tr>
<td>a residential treatment center</td>
<td>supplies (other than room, board and inpatient physician care) at the</td>
</tr>
<tr>
<td></td>
<td>level that would have paid if they had been provided on an outpatient</td>
</tr>
<tr>
<td></td>
<td>basis.</td>
</tr>
</tbody>
</table>
## 2015 FEP Standard and Basic Option Updates

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-dose computed tomography (CT) screenings for lung cancer</td>
<td>Provided for adults ages 55 to 80 who have a history of tobacco use limited to one screening per calendar year</td>
</tr>
<tr>
<td>Diabetes mellitus screening</td>
<td>Provided for adults, limited to one screening per calendar year</td>
</tr>
</tbody>
</table>
| Breast cancer medications                  | • Tamoxifen and Raloxifene covered for women ages 35 and older with an increased risk of breast cancer, who have not been diagnosed with breast cancer  
• Must get drugs from a preferred retail pharmacy or the mail-service prescription drug program (mail service available for standard only) |
| Tocolytic therapy and related services     | Benefits only provided when performed on an inpatient basis              |
| Hepatitis C screening                      | Provided for adults, limited to one screening test per calendar year     |
### Breast Cancer (BRCA) Testing

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRCA testing</td>
<td>• Family history criteria expanded to include both breast and fallopian tube cancer as well as breast and peritoneal cancer</td>
</tr>
<tr>
<td></td>
<td>• Genetic counseling and evaluation services are required before testing (when performed as a preventive service)</td>
</tr>
<tr>
<td></td>
<td>• Prior approval is required for preventive and diagnostic testing</td>
</tr>
<tr>
<td></td>
<td>• Testing is available for males (18 and over) when certain criteria is met</td>
</tr>
</tbody>
</table>
# 2015 FEP Standard and Basic Option Updates

## Blue Distinction® Centers

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
</table>
| Bariatric (subject to requirements), spine or knee and hip replacement surgeries | • Member cost share reduced for inpatient admissions facility services; Standard option ($150 per admission)/Basic option ($100 per day copayment up to $500 per admission)  
• Must pre-certify and verify facility designation as BDC |
| Bariatric laparoscopic banding procedures    | • Outpatient facility expenses reduced when performed at a BDC for laparoscopic gastric banding surgery. Pre-surgical requirements apply. Standard option ($100 per day per facility) / Basic option ($25 per day per facility)  
• Must pre-certify and verify facility designation as BDC |
State Health Plan
presented by Jada Addison
## Standard Plan

<table>
<thead>
<tr>
<th>Services for Standard Plan</th>
<th>2014 Benefit</th>
<th>2015 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$420</td>
<td>$445</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$840</td>
<td>$890</td>
</tr>
<tr>
<td><strong>Copays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>$12</td>
<td>$12</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>$90</td>
<td>$95</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$150</td>
<td>$159</td>
</tr>
<tr>
<td><strong>Coinsurance Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual-Network</td>
<td>$2,400</td>
<td>$2,540</td>
</tr>
<tr>
<td>Family-Network</td>
<td>$4,800</td>
<td>$5,080</td>
</tr>
<tr>
<td>Individual-Out of network</td>
<td>$4,800</td>
<td>$5,080</td>
</tr>
<tr>
<td>Family-Out of network</td>
<td>$9,600</td>
<td>$10,160</td>
</tr>
</tbody>
</table>
Standard Plan

Flu Vaccination

Beginning July 1, 2015, the State Standard plan will begin covering flu shots for adults (over 18).
## Savings Plan

<table>
<thead>
<tr>
<th>Services for Standard Plan</th>
<th>2014 Benefit</th>
<th>2015 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td></td>
<td>Same for 2014.</td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$3,600</td>
<td></td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$7,200</td>
<td></td>
</tr>
<tr>
<td>Coinsurance Maximum</td>
<td></td>
<td>Same for 2014.</td>
</tr>
<tr>
<td>Individual-Network</td>
<td>$2,400</td>
<td></td>
</tr>
<tr>
<td>Family-Network</td>
<td>$4,800</td>
<td></td>
</tr>
<tr>
<td>Individual-Out of network</td>
<td>$4,800</td>
<td></td>
</tr>
<tr>
<td>Family-Out of network</td>
<td>$9,600</td>
<td></td>
</tr>
</tbody>
</table>
Preferred Blue
presented by Mary Ann Shipley
Preferred Blue: Sample ID Cards
BlueChoice HealthPlan
presented by Mary Ann Shipley
BlueChoice Plan Updates

These plans will not be offered in 2015:

• MyChoice: Open Access
• MyChoice: Open Access HDHP
• MyChoice: Open Access Value Plan
• MyChoice (Primary Choice – HMO)
• MyChoice: Individual Coverage
• MyChoice: Individual Coverage HDHP
• CarolinaADVANTAGE
• CarolinaADVANTAGE HDHP

Current members can remain in these plans.
Policy Update to Prior Authorization Requirements

- Not all procedures require prior authorization and/or referrals.
- You can now perform services typically done by a PCP or as part of ACA requirements without an authorization from BlueChoice.
- For detailed information, go to: http://www.BlueChoiceSC.com/providers/news.aspx?article_id=217
These services no longer require prior authorization when performed by a PCP:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT/HCPCS Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>45378-45392</td>
</tr>
<tr>
<td>Continuous overnight pulse oximetry</td>
<td>94762</td>
</tr>
<tr>
<td>Excision of nail</td>
<td>11720-11755</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy</td>
<td>45300, 45330, 45331, 45332, 45333, 45334, 45335, 45338, 45339, 45340</td>
</tr>
<tr>
<td>Iron injection*</td>
<td>J1750</td>
</tr>
<tr>
<td>Paring or cutting of benign lesions</td>
<td>11055-11057</td>
</tr>
<tr>
<td>Spirometry</td>
<td>94010, 94014, 94015, 94016, 94060, 94070, 94375, 94620</td>
</tr>
<tr>
<td>Removal skin tags</td>
<td>11200-11201</td>
</tr>
<tr>
<td>U/S bone density measurement (peripheral)</td>
<td>76977</td>
</tr>
</tbody>
</table>

*Not covered for Health Insurance Marketplace (Exchanges) Plans

A list of these services can be found in the BlueChoice Provider Manual and the Provider News page of www.BlueChoiceSC.com.
Medicare Advantage
presented by Mary Ann Shipley
Important Announcement: Non-Renewal of Medicare Blue℠ and Medicare Blue Saver℠ Plans in 2015

- BlueCross will not be offering Medicare Blue and Medicare Blue Saver plans for 2015.

- BlueCross will continue to offer the MedBlue℠ Rx and MedBlue℠ Rx Plus prescription drug plans in 2015.
What you can expect from us:

• We will still pay an incentive for properly submitted and approved health services that are a part of HEDIS clinical measures for dates of service from January 1, 2014, to December 31, 2014.

• The Medicare Advantage network is still active
  • Provider updates
  • Out-of-state Medicare Advantage members
What you need to do:

• File claims for your patients as soon as possible.
• Continue to reach out to the member(s) listed on your GIC provider report to receive services for identified HEDIS clinical measures at your practice.
• Submit claims eligible for incentives as per the GIC incentive program on or before January 6, 2015.
What to tell your patients:

- Members received notification which included a list of available plans to select from. For assistance finding another plan they can call 800-MEDICARE.
- Have patients with questions contact Customer Service at 888-645-6025.
- Remind patients to keep their notification letters of non-renewal as proof of their special right to buy a Medigap policy or join another Medicare plan.
Reminder about Subjective Objective Assessment Plan (SOAP) Notes

• The SOAP Note Program ended June 30, 2014. We and our business partner, Inovalon, Inc., have determined that sufficient patient data has been collected for our members and the program is complete. Inovalon is an independent company that handled members’ health status documentation on behalf of BlueCross.

• You can no longer submit paper and electronic SOAP notes for the incentive.
New Groups
presented by Mary Ann Shipley
New BlueCross Groups

- Inergy
- Roper St Francis
- ScanSource
- Southeastern Freight Lines

New BlueChoice Groups

- Carolina League Credit Union
- Charming Inns
- City of Goose Creek
- Horizon Scientific
- LW Grocers
- SafeRack
- Whiteford’s, Inc.
BlueChoice HealthPlan Medicaid
presented by Jon Keith, Denille Douglas, Donna O. Thompson & Donese Pinckney
Who We Are

BlueChoice HealthPlan Medicaid entered the South Carolina Medicaid marketplace in 2008. After six years of dedicated service to our member and provider communities, our health plan is continuing its strong momentum and we are still growing. Our staff is dedicated to the Medicaid line of business.

- We are approved in all 46 South Carolina counties
- We have approximately 82,000 members
- We have approximately 10,000 providers in our network
- We have 58 participating hospitals in our network
Tools to Assist You

- **Membership Reports** – Updated monthly for our PCP providers. They identify all members that are assigned to each physician within a PCP group. These reports are available via the secure Provider Access online tool.

- **Medical Loss Ratio Reports** – Generated on a quarterly basis for our PCP providers. Indicates a cost breakdown associated with the specific practice.

- **ER Diversion Reports** – Generated monthly for our PCP providers. Identifies members who are assigned to your physicians and who have visited the ER within the last month. The reports also indicate the member’s diagnosis at the time of his or her ER visit. You can also use the reports to follow up with members who were seen for actual emergencies. You may also choose to contact those members who use the ER as their PCP.
Tools to Assist You

• Gaps in Care Reports – Generated monthly for our PCP providers. These reports identify members that need to be seen for well exams, immunizations, etc.
2015 Provider Incentive Program

• Use your Gaps in Care Reports to identify patients who are in need of well-child visits.
• Providers will receive an additional $30.00 for each well-child visit provided to our members.
• File G8496 in addition to the well-child CPT code.

Incentives for 2015

• Zero to 15 Month
• Three to Six Years
• Adolescent Well Care
The BlueBlast is a monthly, provider-focused newsletter.

It typically includes:

- Important health plan updates
- Healthy Connections announcements
- Billing and claims information
- Frequently asked provider questions
- Community outreach efforts and upcoming events

- It is distributed at the beginning of each month, electronically and via mailed hard copies.
• If you would like to begin receiving the monthly BlueBlast newsletter, please contact your representative.

• Be sure to checkout the special edition, “Best of BlueBlast!” You can access all issues at www.BlueChoiceSCMedicaid.com.
iSelectMD

• In an effort to decrease ER utilization, BlueChoice HealthPlan Medicaid has partnered with iSelectMD for a pilot project.
• iSelectMD employs board-certified, credentialed physicians
• If a member is unable to visit his or her PCP, he or she has access to the iSelect MD physicians for non-emergent issues, such as sinus infections.
• The physicians can prescribe medications to members, if needed.
• All information about the member’s visit, including prescribed medications, will be sent to the PCP.
• Members can access iSelectMD seven days per week, 24-hours per day.
# Contacts

Remember, all contact information for BlueChoice HealthPlan Medicaid is different from BlueChoice, the commercial product.

<table>
<thead>
<tr>
<th>Website: <a href="http://www.BlueChoiceSCMedicaid.com">www.BlueChoiceSCMedicaid.com</a></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Provider Care Center</strong></th>
<th>Verify eligibility, benefits, claim status, general questions, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Voice:</strong> 866-757-8286</td>
<td><strong>Fax:</strong> 912-233-4010 or 912-235-3426</td>
</tr>
<tr>
<td><strong>Monday to Friday:</strong> 8 a.m. to 6 p.m.</td>
<td><strong>TTY:</strong> 866-773-9634</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>24-Hour Nurseline</strong></th>
<th>Registered nurses provide health information on illnesses and options for accessing care, including emergency services, if applicable.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Voice:</strong> 866-577-9710</td>
<td><strong>TTY:</strong> 800-368-4424</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>iSelectMD</strong></th>
<th>Board certified physicians will triage members with minor illnesses.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Voice:</strong> 877-775-3006</td>
<td><strong>24-hours per day, seven days per week</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Utilization Management</strong></th>
<th>Prior authorization and hospital/facility admission notification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Voice:</strong> 866-902-1689</td>
<td><strong>Fax:</strong> 800-823-5520</td>
</tr>
<tr>
<td><strong>Monday to Friday:</strong> 8 a.m. to 5 p.m.</td>
<td><strong>TTY:</strong> 800-368-4424</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Case Management</strong></th>
<th>Care coordination and WIC information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Voice:</strong> 866-757-8286</td>
<td><strong>WIC:</strong> 800-868-0404</td>
</tr>
<tr>
<td><strong>Monday to Friday:</strong> 8 a.m. to 5 p.m.</td>
<td><strong>24 hours per day, seven days per week</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ExpressScripts, Inc.</strong></th>
<th>An independent company that provides pharmacy benefits on behalf of BlueChoice HealthPlan.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Voice:</strong> 866-310-3666</td>
<td><strong>Fax:</strong> 866-807-6241</td>
</tr>
<tr>
<td><strong>Monday to Friday:</strong> 8 a.m. to 9 p.m.</td>
<td><strong>Saturday to Sunday:</strong> 8 a.m. to 6 p.m.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Disease Management</strong></th>
<th>Programs for chronic conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Voice:</strong> 888-830-4300</td>
<td><strong>TTY:</strong> 800-855-2880</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Vision Service Plan (VSP)</strong></th>
<th>An independent company that provides a vision network on behalf of BlueChoice HealthPlan.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Voice:</strong> 800-877-7195</td>
<td><strong>Monday to Friday:</strong> 8 a.m. to 10 p.m.</td>
</tr>
</tbody>
</table>
BlueChoice HealthPlan Medicaid: Claims and Billing
Claims and Billing: Most Common Denials

Ineligible Members at the Time of Service
• Remember to ask each Medicaid beneficiary for his or her member ID card (Healthy Connections and/or BlueChoice HealthPlan Medicaid) and check the SCDHHS eligibility website each time he or she visits your office.

Out-of-Network (OON) Claims Denial
• We pull OON claims reports on a weekly basis, which identifies claims filing issues, as well as OON providers.
• The top OON denial reasons include:
  • Claims filed with no rendering NPI in block 24J
  • Billing with a non-credentialed physician/practitioner as the rendering provider
Duplicates

• Check claim status via the Web at www.BlueChoiceSCMedicaid.com.
• If we denied your claim the first time, please do not refile the same claim again.
• If a correction is needed, please use our Corrected Claim form. You can also contact our Provider Care Center for assistance.
  • To access this form, visit http://www.BlueChoiceSCMedicaid.com/UserFiles/bluechoice/Documents/Providers/Claim_Followup.pdf
Claims Submission

Electronic Data Interchange (EDI) [Payer ID 00403]

• Preferred and fastest way to submit claims
• You can also submit corrected claims electronically through EDI
• To register or submit questions, call 1-800-470-9630

Hard Copy Claims Submissions, Corrected Claims and Correspondence

• To submit a hard copy claim, corrected claim, appeal or any type of correspondence, please send mail to:

  BlueChoice HealthPlan Medicaid
  Attn: Medicaid Claims
  PO Box 100124
  Columbia, SC 29202-3124
Timely Filing, Re-submissions and Appeals

Claim Filing Limits
All providers are allowed 365 days to submit claims.

Claims denied for requests for medical records
We must receive medical records within 60 days of the request.

Corrected Claims
We must receive corrected claims within 90 days of the process date to be considered for payment. This includes changes to coding, units, NPI, etc. You can submit corrected claims electronically or via hard copy.

You must submit corrected claims via hard copy with the Claim Follow Up form. To access this form, visit:

Timely Filing, Re-submissions and Appeals

Appeals

We must receive appeals within 90 days of the process date to consider them for review.

Submit appeals with the Provider Dispute Resolution form. To access this form, visit:
BlueChoice HealthPlan Medicaid: Community Outreach
In the Communities We Serve!
Provider Community Outreach Initiative

The provider community outreach initiative takes a proactive approach to empowering families with health awareness tools through the distribution of resources, health education, and benefits and service information which will stimulate behaviors.

**Types of provider community outreach initiative events:**

- Office appreciation for staff/office anniversary celebration
- Approved prevention presentations (flu/germ prevention, healthy eating and fitness)
- Provider Appreciation Events:
  - **Health Days/Literacy Awareness Events:** Member and eligible education presentations
  - **Tier Three Community Events:** Baby showers or health observance celebrations
  - **Provider Marketing Outreach:** Joint outreach initiatives/provider office events
Value-Added Benefits

In addition to the core member benefits, BlueChoice HealthPlan Medicaid offers additional benefits.

- No copays for urgent care services
- Free Boys and Girls Club memberships
- Free Girl Scout memberships and choice of FREE uniform or Journey Booklet
- I-Select MD services
- New Baby New Mom program
- Discounts on health and wellness programs
- Low copays for generic and brand medications
- No cost for check-ups, circumcisions and flu shots
- Free manual breast pumps
- Gift cards (for healthy behaviors)
- 24-Hour Nurseline
- Disease management
- Car seat program
Community Outreach Team

For information about community outreach initiatives, please contact:

- **Daphney Addison, Outreach Specialist Sr.**
  - Direct: 803-605-9843
  - Email: [Daphney.Addison@wellpoint.com](mailto:Daphney.Addison@wellpoint.com)

- **David Rojas, Outreach Specialist Sr.**
  - Direct: 803-391-1299
  - Email: [David.Rojas@wellpoint.com](mailto:David.Rojas@wellpoint.com)

- **Donna Williams, Marketing Officer**
  - Direct: 803-260-6085
  - Office: 803-382-5167
  - Email: [Donna.Williams@wellpoint.com](mailto:Donna.Williams@wellpoint.com)
Mental Health
presented by Missy Lewis
Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires health insurance plan coverage offered for mental health and substance use treatment services to be no more restrictive than coverage offered for medical and surgical services. MHPAEA’s final rule is applicable for benefit plan years beginning on or after July 1, 2014. Plans with a calendar year benefit period must comply by January 1, 2015.

• For more information on MHPAEA visit:  
  http://www.dol.gov/ebsa/mentalhealthparity/

This link leads to a third party site. That company is solely responsible for the content and privacy policies on its site.
Mental Health Parity

• All health plans renewing on or after July 1, 2014, will no longer require prior authorization for covered mental health and substance use treatment services provided during routine office visits, such as psychiatric evaluation, medication management and psychotherapy.

• Other services, such as admissions, psychological testing and procedures, will continue to require prior authorization due to the member's contract benefits or type of service.

• It is important to remember health plan renewals dates vary. Each plan will independently implement MHPAEA rules.
Mental Health Parity

- During this transition period, authorization may be granted with an expiration date of up to one year for any plans that have not yet renewed and still require preauthorization.

- Upon plan renewal, the member’s deductibles, copayments, coinsurance and out-of-pocket limitations for covered mental health and substance use services will be equal to those of medical and surgical services.
For more information or to get authorization for all levels of care …

Visit www.companionbenefitalternatives.com

Companion Benefits Alternatives (CBA) is a separate company that administers mental health and substance abuse benefits on behalf of BlueCross.
HEDIS Measures: What is the HEDIS Follow-Up After Hospitalization (FUH) measure?

- FUH for Mental Illness Members who were hospitalized for treatment of specific mental health disorders, ages 6 years and older, should have a follow-up appointment with a licensed mental health provider within seven days of discharge.
HEDIS Measures

- The successes of prompt outpatient follow-up include:
  - Improved engagement in outpatient counseling
  - Fewer no-show appointments
  - Reduced readmission rates
- Consider the integral role your office plays in ensuring members are seen promptly, so they can take charge of their recoveries and continue the healing process.
HEDIS Measures

Attention-Deficit Hyperactivity Disorder (ADHD) – Three visits within 10 months

- Initiation Phase – Children with new ADHD medication prescriptions should have follow-up visits with their doctors within 30 days of starting the medications.

- Maintenance Phase – These children should visit their doctors twice more within nine months after their initiation phases.
HEDIS Measures

Antidepressant Management

- Four visits within 12 weeks.
- Acute Phase – Newly diagnosed patients should have at least three follow-up visits within 12 weeks. At least one of the follow-up visits should be with a provider who can write prescriptions.
HEDIS Measures

- Alcohol & Other Drug (AOD) Dependence - Three visits within six weeks

  - Initiation Phase – Newly diagnosed patients with AOD dependence should have a follow-up visit within 14 days.
  
  - Engagement Phase – These patients should have at least two additional AOD services within 30 days after the initiation phase.
HEDIS Measures

• Notify us of your availability for extended office hours or quick-access appointment availability.

• Timely filing of claims ensures that CBA can capture data related to HEDIS measures and prevents records requests for confirmation of attendance at post-discharge appointments.

• For more information about HEDIS, visit http://www.ncqa.org. (This link leads to a third party site. That company is solely responsible for the content and privacy policies on its site.)
Contact Us

• Missy Lewis, RN, BSN- CBA, Case & Disease Management Manager missy.lewis@companiongroup.com

• Natalie Johnston, Director of Provider Network Services natalie.johnston@companiongroup.com

• Network Inquiries: cba.provrep@companiongroup.com

• Telephone: 800-868-1032
Prescription Monitoring Program
presented by Christie Frick, SC DHEC
What is SCRIPTS?

- SCRIPTS requires dispensing practitioners and pharmacies to collect and report dispensing activity of all CII-CIV controlled substances. As of September 1, 2014, SCRIPTS had more than 63 million records.
- It is intended to improve the state's ability to identify and stop diversion of prescription drugs in an efficient and cost-effective manner that will not impede the appropriate medical utilization of licit controlled substances where there is a valid prescriber-patient or pharmacist-patient relationship.
Why is SCRIPTS important to providers?

- You can view prescriptions your patient had filled and who prescribed them as well as who dispensed the prescription.
- Your BlueCross provider advocate will share with you your patients being treated with a CII-CIV controlled substance and the total number of prescriptions for controlled substances you have prescribed.
- If you receive a letter from us that indicates your patient has been identified as potentially overusing/abusing a prescription drug, you can review SCRIPTS to determine prescribing patterns for that patient.
What should you do?

• View a 12-minute online training course about SCRIPTS at http://www.careermapper.net/scpmp. (This link leads to a third party site. That company is solely responsible for the content and privacy policies on its site.)

• Sign up to use SCRIPTS if you are not a registered user. You will need to complete DHEC’s Practitioner/Pharmacist Database Access Form.

• Talk with your patients about any adverse findings found on your SCRIPTS report. You can lawfully monitor his or her prescriptions in accordance with SC Code Ann. Section 44-53-1610 et seq. (Prescription Monitoring Act).

• Regularly review your BlueCross provider report card with your provider advocate to determine the impact you are having on improving patient prescribing patterns.
Need more information?

• Additional information about SCRIPTS use and access is available at: http://www.scdhec.gov/Health/FHPF/DrugControlRegisterVerify/PrescriptionMonitoring/. (This link leads to a third party site. That company is solely responsible for the content and privacy policies on its site.)
Pharmacy Management
presented by Deno Sebastian
Commercial Business Update

• Overview of 2015 pharmacy changes affecting BlueCross and BlueChoice fully insured and many self-funded groups

• Medicare Advantage:
  • Has its own formulary and drug management programs
  • Prime will continue as the pharmacy benefits manager (PBM) for Part D products. Prime is an independent company that offers pharmacy benefits management on behalf of BlueCross.

• ACA (Marketplace) products:
  • Caremark continues to be the PBM for both non-specialty and specialty drug coverage. Caremark is an independent company that provides pharmacy benefits management on behalf of BlueCross.
Commercial Business Update

- There is a Covered Drug List and drug management programs that are unique to these products
Overview: Blue Cross Pharmacy Management Update

- Preferred Drug List Changes
- Utilization Management Program Changes
  - Prior Authorization
  - Quantity Management
- Specialty Pharmacy
Preferred Drug List Changes

Drugs Moving to Non-Preferred

- Accu-Chek Test Strips

Preferred Drug List Alternatives

- OneTouch Test Strips
- Advair, Symbicort
Prior Authorization Changes Effective January 1, 2015

Applies to groups that have the prior authorization program.

- Providers must request and receive prior authorization for a member to have coverage for these drugs in 2105

- Visit the Prescription Drug Information page on our website, SouthCarolinaBlues.com for details.
### Prior Authorization Changes Effective January 1, 2015

<table>
<thead>
<tr>
<th>Condition</th>
<th>Drugs Requiring Prior Authorization</th>
<th>Alternative(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis/Pain</td>
<td>Naprelan, Pennsaid, Sprix, Zipsor, Zorvolex</td>
<td>generic NSAIDS</td>
</tr>
<tr>
<td></td>
<td>Duexis, Vimovo</td>
<td>generic NSAIDS plus generic PPIs</td>
</tr>
<tr>
<td>Asthma/COPD</td>
<td>Dulera</td>
<td>Advair, Symbicort</td>
</tr>
<tr>
<td>Diabetes – Test Strips</td>
<td>All test strips <em>other than</em> One Touch</td>
<td>One Touch test strips*</td>
</tr>
<tr>
<td>Diabetes – SGLT2 (new MNPA category)</td>
<td>Farxiga</td>
<td>Invokana, Invokamet</td>
</tr>
<tr>
<td>Diabetes – GLP-1 (new MNPA category)</td>
<td>Byetta</td>
<td>Bydureon, Victoza</td>
</tr>
<tr>
<td>Muscle Relaxants (new MNPA category)</td>
<td>Amrix</td>
<td>cyclobenzaprine</td>
</tr>
</tbody>
</table>
Quantity Management and Step Therapy Updates

- **Quantity Management:**

  **Compounds:**
  - Limited to one prescription for the same compounded drug every 25 days
  - Intent is to keep pharmacies from split billing to get around the dollar threshold for PA (currently $400, moving to $300 in 2015).

- **Step Therapy:**

  No Changes
Specialty Drug List Update

• Drugs are added to the Specialty Drug List as soon as they are approved.

• Prior authorization, when appropriate, will be added as soon as possible.

• The Specialty Drug List will be updated every quarter.

This and all our drug management program lists can be found on both the member or the provider section of www.SouthCarolinaBlues.com.
BlueChoice Commercial Business

BlueChoice HealthPlan Medicaid:
• Has its own formulary and drug management programs
• WellPoint administers the pharmacy benefit. WellPoint is an independent company that administers this program on behalf of BlueChoice HealthPlan.

ACA (Marketplace) products:
• Caremark continues to be the PBM for both non-specialty and specialty drug coverage
• There is a Covered Drug List and drug management programs that are unique to these products
• New Fall 2014: Searchable Covered Drug List at www.BlueChoiceSC.com
Overview: BlueChoice Pharmacy Management Update

- Preferred Drug List Changes
- Utilization Management Program Changes
  - Prior Authorization
  - Quantity Limits
- Specialty Pharmacy
Prescription Drug List Changes

Drugs Moving to Non-Preferred

Accu-Chek Test Strips

Prescription Drug List Alternatives

OneTouch Test Strips

Dulera

Advair, Symbicort
Prior Authorization Changes Effective January 1, 2015

• All BlueChoice groups have the prior authorization program.

• Providers must request and receive prior authorization for a member to have coverage for these drugs in 2015.

• View the full Prescription Drug List for more information, on our website, www.BlueChoiceSC.com.
## Prior Authorization Changes Effective January 1, 2015

<table>
<thead>
<tr>
<th>Condition</th>
<th>Drugs Requiring PA</th>
<th>Alternative(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis/Pain</td>
<td>Naprelan, Pennsaid, Sprix, Zipsor, Zorvolex</td>
<td>generic NSAIDS</td>
</tr>
<tr>
<td></td>
<td>Duexis, Vimovo</td>
<td>generic NSAIDS plus generic PPIs</td>
</tr>
<tr>
<td>Asthma/COPD</td>
<td>Dulera</td>
<td>Advair, Symbicort</td>
</tr>
<tr>
<td>Diabetes – Test Strips</td>
<td>All test strips <em>other than</em> One Touch</td>
<td>One Touch test strips*</td>
</tr>
<tr>
<td>Diabetes – SGLT2 (new MNPA category)</td>
<td>Farxiga</td>
<td>Invokana, Invokamet</td>
</tr>
<tr>
<td>Diabetes – GLP-1 (new MNPA category)</td>
<td>Byetta</td>
<td>Bydureon, Victoza</td>
</tr>
<tr>
<td>Muscle Relaxants (new MNPA category)</td>
<td>Amrix</td>
<td>cyclobenzaprine</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Micardis/Micardis HCT</td>
<td>generic ARBs</td>
</tr>
</tbody>
</table>
Quantity Management and Step Therapy Updates

Quantity Management:

**Compounds**

- Limited to one prescription for the same compounded drug every 25 days.
- Intent is to keep pharmacies from split billing to get around the dollar threshold for PA (currently $400, moving to $300 in 2015).

Step Therapy:

**No Changes**
Specialty Drug List Update

• Drugs are added to the Specialty Drug List as soon as they are approved.

• Prior Authorization, when appropriate, will be added as soon as possible.

• The Specialty Drug List will be updated every quarter.
Educational Outreach for BlueCross and BlueChoice

Member-specific mailings were sent in November:

• Members impacted by tier changes and Utilization Management program changes
EDI/ICD-10
presented by Brian Butler
ICD-10 Update

• On July 31, 2014 the U.S. Department of Health and Human Services (HHS) issued a rule finalizing October 1, 2015, as the new compliance date for health care providers, health plans and health care clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases.

• This deadline allows providers, insurance companies and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready to go on Oct. 1, 2015.
DRG Shift Summary

- Areas with the Highest Percentage of Shifts
  - Circulatory System – 27.18 percent
  - Digestive System – 22.37 percent
  - Injuries, Poisoning and Toxic Effects of Drugs – 31.25 percent
  - Male Reproductive System – 50 percent
  - Musculoskeletal System and Connective Soft Tissue – 20.27 percent
  - Factors Influencing Health Status – 28.57 percent
  - Multiple Significant Trauma – 25 percent
  - DRGs Associated with all MDCs – 71.43 percent
Everyone covered by the Health Insurance Portability and Accountability Act (HIPAA), including mental health and substance abuse providers, must implement ICD-10 for medical coding for dates of service on or after October 1, 2015.
DSM-4 to DSM-5 Conversion

- The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* was developed to facilitate a seamless transition into immediate use by clinicians and insurers to maintain continuity of care. The new manual represents a step forward in more precisely identifying and diagnosing mental disorders.

- Since DSM-5 is completely compatible with the HIPAA-approved ICD-9-CM and ICD-10-CM coding system, the revised criteria for mental disorders can be used.
For More Information:
visit [http://www.hipaacriticalcenter.com/](http://www.hipaacriticalcenter.com/) or contact edi.services@bcbssc.com
BlueCard Program
presented by Sharman Williams
Overview

- BlueCard is a program that enables members to get health care services while traveling or living in another Blue Plan’s service area.
  - For example, a BlueCross BlueShield of Massachusetts member travels to South Carolina and should file the claim with BlueCross BlueShield of South Carolina.

- The program equips providers with one source for:
  - Claims submission
  - Claims payment
  - Adjustments
  - Issue resolution involving other Blue Plans
Let’s talk about how BlueCard works!

What happens if a member gets services in South Carolina but has BlueCross BlueShield of Massachusetts coverage?
Advantages of the BlueCard Program

- Ability to service all Blue members nationwide
  - Approximately 92.6 million members

- Ability to service all Blue members while contracting with only BlueCross BlueShield of South Carolina
  - Easy access to member eligibility, benefits and pre-certification/pre-authorization
  - Reimbursement from BlueCross BlueShield of South Carolina
  - A one-stop shop for all claims-related activities:
    - Claim submissions
    - Claim inquiries
    - Claim status
    - Payment
Home Plan

- The Plan that holds the patient’s membership and benefits information.

- Responsibilities:
  - Enrollment process and issuing ID cards.
  - Benefit, membership and eligibility determination.
  - All member interactions including member service calls.
  - Member education.
  - Claim adjudication (benefit application) and creation of member EOBs.
Host Plan

• The Plan that is local for the provider that renders services.

• Responsibilities:
  • Perform provider contracting, rate negotiation, training and education.
  • Receive claims from local providers and price claims.
  • Route claim information with pricing data to the Control/Home Plan.
  • Send remittance notice and reimbursement to provider.
  • Handle ALL provider inquiries and provider service.
BlueCard Claims Process

- South Carolina contracted provider submits claim to BlueCross.
- BlueCross 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 BlueCross.
- Home Plan sends EOB to member.
- BlueCross sends remittance and payment to South Carolina contracted provider.
Medical Records

If records are requested:

• Forward all requested medical records to BlueCross and BlueShield of South Carolina within **10 calendar days**.

• Follow the submission instructions given on the request, using the specified physical or email address or fax number. Include your fax number, too.
Medical Records

If records are requested:

- Use the Return Coverage Page with the request when submitting the medical records.
- Only send the minimum necessary information requested.
Other Medical Records

The Blue Cross and Blue Shield Association has selected Verisk Health, Inc. to gather medical records behalf of BlueCross Plans for non-claims related purposes.

Verisk is the medical records retrieval coordinator (MRRC) to support risk adjustment, HEDIS and other government-required programs related to the ACA.

Verisk’s medical record retrieval functions involve:

- Retrieving and digitizing records (e.g., PDF)
- Associating images to patient information for better indexing
- Delivering records to requesting Plans through a secure online portal
- Storing records electronically for reference
Provider Financial Responsibility

Effective July 1, 2014, providers are responsible for getting pre-service review for inpatient facility services when required by the member’s contract.

Ways to get review from other Blue Plans:

- Call the utilization management/precertification number on the back of the card.
- Call BlueCard Eligibility at 800-676-BLUE (2583). Choose the option for precertification.
- Submit a HIPAA 278 transaction
- Use the electronic provider access (EPA) tool in My Insurance ManagerSM
The EPA Tool

- Enables you to use My Insurance Manager to access out-of-area members’ Blue Plan (Home Plan) provider portals through a secure routing mechanism to conduct electronic pre-service review.
- A separate sign-on is **not** required once you have been routed to the Home Plan landing page.
- The availability of EPA (electronic provider access) will vary depending on the capabilities of each Home Plan.
## EPA Tool

<table>
<thead>
<tr>
<th>Plans that have not implemented EPA</th>
<th>Implementation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS New Jersey</td>
<td>December 31, 2014</td>
</tr>
<tr>
<td>BCBS Minnesota</td>
<td>April 2015</td>
</tr>
<tr>
<td>BCBS Montana</td>
<td>July 2015</td>
</tr>
<tr>
<td>Premera Blue Cross</td>
<td>December 31, 2014</td>
</tr>
<tr>
<td>BCBS Rhode Island</td>
<td>December 31, 2014</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plans that will not implement EPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS Arizona</td>
</tr>
<tr>
<td>HealthNow New York</td>
</tr>
<tr>
<td>BCBS Kansas City</td>
</tr>
<tr>
<td>Triple S BCBS</td>
</tr>
<tr>
<td>BCBS Wyoming</td>
</tr>
</tbody>
</table>

These Plans are all independent licensees of the Blue Cross and Blue Shield Association.
BlueCard Precertification/Medical Policies

Access via My Insurance Manager

- Check medical policies
- Get general precertification requirements for out-of-area Blue patients
- Get contact information to initiate precertifications
BlueCard Education Resources

www.SouthCarolinaBlues.com
  • BlueCard Program Provider Manual
  • 2014 Provider Office Administrative Manual
  • Webinar trainings
  • Bulletins

And your provider advocate!
# BlueCard Quick Tips

<table>
<thead>
<tr>
<th>Request</th>
<th>BlueCross BlueShield of South Carolina</th>
<th>Member’s Home Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility and Benefits</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Claim Submission</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Claim Status</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Medical Review Request</td>
<td>☑</td>
<td></td>
</tr>
</tbody>
</table>

**BlueCross**

[www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)

My Insurance Manager

800-868-2510

**Member’s Home Plan**

View ID card for prior authorization contact info

My Insurance Manager

800-676- BLUE (2583)
Ancillary Claims
presented by Sharman Williams
Ancillary Claims Filing

• Where to file claims …

Lab Provider

Where the specimen was collected

Durable/Home Medical Equipment Provider

OR

Where the referring physician is located

Specialty Pharmacy Provider

Where the equipment or supplies were delivered or purchased

Where the ordering physician is located
Ancillary Provider Tips

• It is important that you use in-network participating ancillary providers to reduce the possibility of additional member liability for covered benefits.

• Members are financially liable for ancillary services not covered under their benefit plan.
  • It is the provider’s responsibility to request payment directly from the member for non-covered services.

• Physicians should only refer patients to in-network lab processing and drawing stations.
  • LabCorp is the exclusive lab provider for BlueChoice members.
Web Tools
presented by Sandy Sullivan
My Insurance Manager

• In order to view claim status, complete authorizations, verify benefits and eligibility, or view your remits you must have a unique username registered in My Insurance Manager. Each person in your office who will use this tool should also have his or her own unique username as well.

• Due to the security of the information found within My Insurance Manager, you should never share your login information with anyone. Please contact us if you feel your username or password has been compromised.
My Insurance Manager Updates

**Great news!** We have updated the registration process for My Insurance Manager. It’s much more simple.

- You no longer need your credentialing ID
- We now verify claim data that you submit
My Insurance Manager Updates

- A profile administrator must approve office staff profiles. The Administrator Directory page displays once you’ve created your user information. This page provides a listing of all profile administrators for your tax ID number.
Can I verify benefits and eligibility for BlueCard members through My Insurance Manager?

- The members’ Home Plans maintain members’ benefits and eligibility for BlueCard.
- My Insurance Manager can provide you with eligibility information and general benefits at the service type level for BlueCard members.
How do I verify coinsurance on the website?

- Open the hidden eligibility response section in My Insurance Manager and check the member’s coverage level.
- In reviewing the global benefits for an individual, you will be able to determine that a member has met his or her individual out of pocket (OOP).
Print a Directory Tool

We have redesigned our Print a Directory online tool. It is now easier for our members to create a personalized directory of South Carolina network providers and facilities. Exciting enhancements include:

- Easier search process for single provider entries, and a complete or facility directory for a service region or specific location
- Email or text results
- Map and driving directions
- Improved technology to work on smart phones and tablets

Let your patients know they can find Print a Directory within My Health Toolkit® and on our websites.
STATchat℠

We have made improvements to our STATchat feature in My Insurance Manager.

• We made these changes to enhance audio quality to improve your overall STATchat experience.

• If you have trouble hearing the representative once you have launched STATchat, click the “Having trouble with the audio?” button at the bottom of the window. We will adjust your settings to comply with the enhancements.

• If you continue to have problems, we have a technical team available to assist with your STATchat conversion at 855-229-5720.

Did you know…

1:41 minutes

...is the average speed of answer (ASA) for STATchat users!
@myinsurancemanager.com

- If emails from My Insurance Manager are ending up in your junk folder, you may be missing out on registration confirmations.
- Please remember to add @myinsurancemanager.com to your list of trusted emails.

https://provider.bcbssc.com/wps/portal/hcp/providers/home
Web Prior Authorizations
presented by Sandy Sullivan
Preferred method of submissions for all providers!

- We accept and process 100 percent of referral requests.
- 80 percent of Fast Track submissions receive an automatic precertification.
- We grant most other precertifications within 24 hours of submission.
- Provide complete information to avoid delays.
- You can submit clinical documentation right in the notes field if necessary.
- Our internal staff of precertification technicians and nurses works very closely together to review and authorize your patients’ procedures as quickly as possible.
## Automatic Authorizations

The most frequently requested BlueCross services that approve on the Web without pending:

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal delivery</td>
<td>EGD</td>
<td>Confirmed MI</td>
</tr>
<tr>
<td>Vaginal delivery, State notification</td>
<td>Pancreatitis</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>Total knee</td>
<td>GI bleed</td>
<td>Colectomy</td>
</tr>
<tr>
<td>Chest pain – R/O MI</td>
<td>CVA – confirmed</td>
<td>Echo</td>
</tr>
<tr>
<td>C-section</td>
<td>Renal calculi</td>
<td>Asthma</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>Colonoscopy</td>
<td>C-section, State notification</td>
</tr>
<tr>
<td>Sleep studies</td>
<td>Atrial fibrillation</td>
<td>Pyelonephritis</td>
</tr>
<tr>
<td>Total hip</td>
<td>Diverticulitis</td>
<td>DKA</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Cholecystitis</td>
<td></td>
</tr>
<tr>
<td>Sepsis</td>
<td>Epidural steroid injection</td>
<td></td>
</tr>
</tbody>
</table>
The most frequently requested BlueChoice services that approve on the Web without pending:

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedic surgery referral</td>
<td>Neurology referral</td>
</tr>
<tr>
<td>Dermatology referral</td>
<td>Endocrinology referral</td>
</tr>
<tr>
<td>Ophthalmology referral</td>
<td>Hematology/oncology referral</td>
</tr>
<tr>
<td>Gastroenterology referral</td>
<td>Pulmonary disease referral</td>
</tr>
<tr>
<td>Gynecology referral</td>
<td>Cholecystectomy lap outpatient</td>
</tr>
<tr>
<td>Surgery consult referral</td>
<td>Allergy and immunology referral</td>
</tr>
<tr>
<td>Cardiology referral</td>
<td>Physiatrist referral</td>
</tr>
<tr>
<td>ENT (otolaryngology) referral</td>
<td>Hernia repair, all types</td>
</tr>
<tr>
<td>Urology referral</td>
<td>Cataract extraction</td>
</tr>
<tr>
<td>Podiatry referral</td>
<td>Lithotripsy-renal (ESWL) facility</td>
</tr>
</tbody>
</table>

Automatic Authorizations

Web Prior Authorizations

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology referral</td>
<td>Physiatrist referral</td>
</tr>
<tr>
<td>Physiatrist referral</td>
<td>Cardiac rehabilitation facility</td>
</tr>
<tr>
<td>Endocrinology referral</td>
<td>Venous access insert/revise</td>
</tr>
<tr>
<td>Internal medicine referral</td>
<td>Optometry-medical only</td>
</tr>
<tr>
<td>Neurosurgery referral</td>
<td>Neurosurgery referral</td>
</tr>
<tr>
<td>Optometry-medical only</td>
<td>Neurosurgery referral</td>
</tr>
<tr>
<td>Allergy and immunology referral</td>
<td>Cardiac catherization outpatient</td>
</tr>
<tr>
<td>Cardiac catherization</td>
<td>Cardiac catherization outpatient</td>
</tr>
<tr>
<td>Hernia repair, all types</td>
<td>ORIF upper limb-outpatient</td>
</tr>
<tr>
<td>Cataract extraction</td>
<td>Nephrology referral</td>
</tr>
<tr>
<td>Knee arthroplasty, total</td>
<td>Nephrology referral</td>
</tr>
</tbody>
</table>
Do we need to initiate a new referral request with the patient’s primary care physician when a referral expires?

- Primary care physicians can make referrals to in-network specialists online with My Insurance Manager.
- Both primary care physicians and specialists can request specialist referral extensions on the Web.
- Log into My Insurance Manager and under the Patient Care heading, choose Health, Pre-Certification/Referral.
Web Prior Authorization Tips

• Be as specific as possible.
• Check to see if the procedure or service is available through the Fast Track option.
• Refrain from using the miscellaneous option.
  • If you don’t see a specific procedure or service through the Fast Track options, you can create a customized pre-certification.
  • Customized pre-certifications will pend for review.
  • When using the customized pre-certification option, be sure to include specific information in the comments/notes field.
Clinical Attachment – NEW!

Soon you will be able to attach medical records to precertification requests electronically in My Insurance Manager.

- This feature is available for services that do not automatically approve.
- Records must be in a PDF format (other formats to come!).
- You can attach up to 10 documents at a time.
- The maximum size of a single attachment is 30MB.
- When you select a document, you can preview it to ensure it is exactly what you want to submit and remove it if necessary.
Clinical Attachment – NEW!

- For BlueCross members, if we receive a request and need additional clinical information from you, we will send you a request with a “Request ID” that is unique to that case.
- You can add additional documents when checking the authorization status but you must include the Request ID with future attachments.
- Including the Request ID ensures we can easily identify the member’s case and combine clinical information with the documentation already on file.
- Once you attach the file, you will be able to preview the document.
NIA & Radiation Oncology Program
presented by Sandy Sullivan
NIA Overview

- Non-emergency procedures requiring pre-authorization are: Computerized Axial Tomography (CAT) Scan, Positron Emission Tomography (PET) Scan, Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA).

- Visit www.RadMD.com or call to request pre-authorization or to check the status of a pre-authorization request. (This link leads to a third party website. That company is solely responsible for the contents and privacy policy on its site.)
  - BlueCross calls: 866-500-7664
  - BlueChoice calls: 888-642-9181
Radiology Program Details

<table>
<thead>
<tr>
<th>BlueCross</th>
<th>BlueChoice</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.radmd.com">www.radmd.com</a></td>
<td><a href="http://www.radmd.com">www.radmd.com</a></td>
</tr>
<tr>
<td>• CAT Scans</td>
<td>• CAT Scans</td>
</tr>
<tr>
<td>• MRI</td>
<td>• MRI</td>
</tr>
<tr>
<td>• MRA</td>
<td>• MRA</td>
</tr>
<tr>
<td>• PET Scans</td>
<td>• PET Scans</td>
</tr>
<tr>
<td></td>
<td>• Cardiac Computed Tomography</td>
</tr>
<tr>
<td></td>
<td>Angiography (CCTA)</td>
</tr>
<tr>
<td></td>
<td>• Nuclear Cardiology Exams</td>
</tr>
</tbody>
</table>

Visit our websites for more information, including a complete list of alpha prefixes for members who require authorization through NIA, NIA reference guides and frequently asked questions.
NIA Radiation Oncology Program

- On January 1, 2015, BlueCross and BlueChoice will launch a Radiation Oncology Utilization Management program.
- NIA Magellan will provide these radiation oncology benefit management services through its Radiation Oncology Solution program.
- NIA Magellan’s Radiation Oncology Solution is designed by physicians, for physicians, to ensure that services within the radiation therapy treatment plan are clinically appropriate for each patient’s specific condition.
NIA Radiation Oncology Services

All of these radiation treatment plans will require prior authorization based on medical necessity review:

- Low-dose-rate (LDR) Brachytherapy
- High-dose-rate (HDR) Brachytherapy
- Two-dimensional Conventional Radiation Therapy (2D)
- Three-dimensional Conformal Radiation Therapy (3D-CRT)
- Intensity Modulated Radiation Therapy (IMRT)
- Image Guided Radiation Therapy (IGRT)
- Stereotactic Radiosurgery (SRS)
- Stereotactic Body Radiation Therapy (SBRT)
- Proton Beam Radiation Therapy (PBT)
- Intra-Operative Radiation Therapy (IORT)
- Neutron Beam Therapy
- Hyperthermia
NIA Radiation Oncology Matrix


Defer to health plan policies for procedures not listed in the matrix.
RadMD Website

http://www1.radmd.com/

This link leads to a third party site. That company is solely responsible for the content and privacy policies on its site.
Additional Provider Updates
presented by Teosha Harrison
## Case Management Programs

<table>
<thead>
<tr>
<th>Prevention and Wellness</th>
<th>Condition Management</th>
<th>Disease Management</th>
<th>Critical Health Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Obesity</td>
<td>Back Care</td>
<td>ADHD</td>
<td>Care Calls</td>
</tr>
<tr>
<td>Children’s Health</td>
<td></td>
<td>Asthma</td>
<td>Case Management</td>
</tr>
<tr>
<td>Cholesterol Management</td>
<td>Chronic Kidney Disease (pre-ESRD)</td>
<td>Bipolar</td>
<td>Emergency Room Diversion Program*</td>
</tr>
<tr>
<td>Men’s Health</td>
<td>High Blood Pressure</td>
<td>COPD</td>
<td>End-Stage Renal Disease (ESRD)</td>
</tr>
<tr>
<td>Preconception Care</td>
<td>High Cholesterol</td>
<td>Depression</td>
<td>NICU Case Management</td>
</tr>
<tr>
<td>Prehypertension</td>
<td>Irritable Bowel Syndrome (IBS)</td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Stress Management</td>
<td>Maternity</td>
<td>Heart Disease</td>
<td></td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>Metabolic Health</td>
<td>Heart Failure</td>
<td></td>
</tr>
<tr>
<td>Weight Management</td>
<td>Migraine</td>
<td>MOMS Health</td>
<td></td>
</tr>
<tr>
<td>Women’s Health</td>
<td>Postpartum Care</td>
<td>Recovery Support</td>
<td></td>
</tr>
</tbody>
</table>

*For BlueChoice Commercial and Exchange members only.

New Programs are in blue.
72-Hour Pre-Admission Testing

- These plans will accept your claims with a 41 occurrence code: commercial BlueCross and BlueChoice plans, Medicare Advantage and Health Insurance Marketplace (Exchanges).
- State Health Plan will not accept a 41 occurrence code. You must file separate claims for pre-admission testing.

Bundling Guidelines

- Participating providers cannot balance bill members when claims are considered mutually exclusive, incidental or integral to the primary services rendered.
Policy Change to Urine Drug Testing (UDT)

• Qualitative/screening (or point-of-care) UDT: reimburse one unit of CPT Code G0431 or G0434 per encounter.
• Qualitative/confirmatory UDT: reimburse one unit of CPT Code 80102
• Quantitative UDT: considered as investigational and/or experimental
• We will not reimburse for claims you file with CPT codes 80100, 80101 and 80104. You will receive a message on your remittance advice that states we do not provide reimbursement for this service.

Encrypted Emails

• Proofpoint Encryption secures our messages that contain PHI.
• For registration or to reset your password, please contact the Technical Support Center at 855-229-5720 for assistance.
Flu Shots

- Advise your patients to get a flu shot annually.
- You should not bill an office visit in conjunction with the flu shot if the sole purpose for a patient’s visit is to get a flu shot.
- Use diagnosis code V0481.
Proper Use of Common Numerical Modifiers

- Here is helpful information on numerical modifiers and how to use them for medical specialty services. This is not a comprehensive list.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>You should:</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>Significant, separately identifiable evaluation &amp; management service by same physician on same day of procedure or other service</td>
<td>Append this modifier with an evaluation and management service done on the same day with other procedure(s) done by the same physician</td>
</tr>
<tr>
<td>26</td>
<td>Professional component</td>
<td>Use this modifier only for charges from the physician of a service or procedure</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral procedure</td>
<td>Append this modifier for procedures billable as bilateral, performed same day, same operative session, on identical anatomical sites or organs</td>
</tr>
<tr>
<td>57</td>
<td>Decision for surgery</td>
<td>An evaluation and management service resulted in the initial decision to perform surgery during the E/M encounter</td>
</tr>
<tr>
<td>59</td>
<td>Distinct procedural service</td>
<td>Use this modifier only if the other procedure is a separately identifiable procedure code. Do not use this modifier for E/M codes</td>
</tr>
</tbody>
</table>
### Post Service Medical Management (PSMM) Reminders

<table>
<thead>
<tr>
<th>DO</th>
<th>DO NOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Provider Services before submitting an appeal</td>
<td>Submit a review for claim status or for a service that is not a covered benefit</td>
</tr>
<tr>
<td>Attach all applicable medical records and supporting information to the Medical Review Form</td>
<td>File an appeal for new and/or corrected claims</td>
</tr>
<tr>
<td>Request a reconsideration for medical necessity, multiple surgery or medical care a patient receives on the same day, or extenuating medical circumstances</td>
<td>Request a reconsideration for claims that include a primary insurer Explanation of Benefits (EOB)</td>
</tr>
</tbody>
</table>

- It generally takes BlueCross 30 days to complete reconsideration reviews and appeals.
- After the PSMM review is complete, the appropriate service area can then initiate claim adjustments or generate letters of denial to providers.
- If your office consistently files **inappropriate medical reviews**, an education specialist can initiate a training session to discuss proper procedures.
24/7 Provider Access

Your BlueChoice contract indicates physician accessibility 24 hours a day, seven days a week. For those who are non-compliant, your provider advocate will contact you.

<table>
<thead>
<tr>
<th>Compliant</th>
<th>Non-Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answering service</td>
<td>Phone rings and does not answer</td>
</tr>
<tr>
<td>Answering machine that transfers to service</td>
<td>Answering machine states office is closed</td>
</tr>
<tr>
<td>Answering machine with the number for the on-call person after hours</td>
<td>Answering machine does not state the on-call person will call them back</td>
</tr>
<tr>
<td>Answering machine that states to leave a message and the person on call will call back</td>
<td>Answering machine refers the patient to the ER or to call 911 with no contact information for the doctor for non-life-threatening conditions</td>
</tr>
<tr>
<td>Any situation that provides the caller with information on how to contact the person on call after hours</td>
<td>Any situation that is in place that has no information about how to contact the on-call person after hours</td>
</tr>
</tbody>
</table>
Provider Credentialing Updates

What forms do I need to complete in order to be credentialed?

Physicians and other health care professionals can apply for credentialing using the South Carolina Uniform Credentialing Application (SCUCA), which covers credentialing for BlueCross and BlueChoice HealthPlan plans.

We require this documentation with your application:

- State license(s)
- Current DEA certificate
- Proof of malpractice coverage, including supplemental coverage
- Board specialist certificate, if applicable
- Electronic Claims Filing Requirement form (page 10 of the SCUCA application)
Provider Credentialing Updates

What forms do I need to complete in order to be credentialed?

• NPI (National Provider Identifier)/NPPES (National Plan and Provider Enumeration System) confirmation letter or email
• A signed contract for each network to which you wish to apply

Please email your completed application and documentation to provider.cert@bcbssc.com or fax to 803-264-4795. Make sure you include all requested documentation, as we will not process applications that are missing required information.
Provider Credentialing Updates

What forms do I need to complete in order to be credentialed with BlueCross and BlueChoice for mid-level and hospital-based providers?

These specialties require the Registration Form for Mid-Level and Hospital-Based Providers:

- Anesthesia
- Pathology
- Radiology
- Physician Assistants
- Nurse Practitioners
- Hospitalists
- Emergency Medicine

This form applies to BlueCross, State Health Plan and BlueChoice only. (BlueChoice HealthPlan Medicaid will require the full SCUCA.)
Provider Credentialing Updates

We require this documentation with your application:

• State license(s)
• Electronic Claims Filing Requirement form
• NPI (National Provider Identifier)/NPPES (National Plan and Provider Enumeration System) confirmation letter or email
• A signed contract signature page for each network to which you wish to apply

Can the practitioner see patients while he or she is being credentialed?

• Yes, a licensed practitioner can see patients while he or she is being credentialed. Claims are not guaranteed to process in network, however, until the credentialing process is complete. For individual network agreements, the network effective date is the credentialing committee approval date.
Top Five Reasons for Incomplete Credentialing Applications

1. Missing network contracts.
2. Missing malpractice insurance.
3. Missing Medicaid disclosure/current CLIA (Clinical Laboratory Improvement Amendments).
5. Specialty mismatch from practitioner credentials.
Rendering Provider Requirement

• We are going to include edits in the system to require physicians file with their rendering information on claims when appropriate. You should file with the rendering information on your claims.

Specific Coding and Reporting

• Be as specific as possible in providing a diagnosis code for patients. You must document all diagnosis codes in the patient’s chart. Submit all diagnosis codes appropriate for that patient at every visit.
Affordable Care Act
presented by Ashlie Graves
Essential Health Benefits

Benefits include services in 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Habilitative and rehabilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including vision care*

*Note: Pediatric dental services are not covered in 2015.
Preventive Coverage

The ACA requires non-grandfathered plans to cover certain preventive care services at **no cost-sharing** when in-network providers provide services.

- We base immunization guidelines on those from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA) guidelines, including the American Academy of Pediatric Bright Futures recommendations.

USPSTF, ACIP, CDC and HRSA are independent organizations that provide health information for BlueCross and BlueChoice.
Preventive Coverage

- The preventive services provisions of the law apply to non-grandfathered health plans. This includes both individual health plans and employer-sponsored (group) health plans.

Services the USPSTF considers preventive include:

<table>
<thead>
<tr>
<th>Service</th>
<th>Patient Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal aortic aneurysm screening (one-time)</td>
<td>Men ages 65–75 who have smoked</td>
</tr>
<tr>
<td>Alcohol misuse screening and counseling</td>
<td>Adults ages 18 and over</td>
</tr>
<tr>
<td>Anemia screening</td>
<td>Pregnant women regardless of age</td>
</tr>
<tr>
<td>Aspirin to prevent cardiovascular disease</td>
<td>Men ages 45–79</td>
</tr>
<tr>
<td></td>
<td>Women ages 55–79</td>
</tr>
<tr>
<td>Bacteriuria screening</td>
<td>Pregnant women</td>
</tr>
<tr>
<td>Blood pressure screening</td>
<td>Adults ages 18 and over</td>
</tr>
<tr>
<td>BRCA risk assessment and genetic counseling/testing</td>
<td>Women with family history/risk factors</td>
</tr>
<tr>
<td>Breast cancer preventive medications²</td>
<td>Women with family history/risk factors (12/24/2014)</td>
</tr>
</tbody>
</table>
## Preventive Coverage

<table>
<thead>
<tr>
<th>Service</th>
<th>Patient Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer screening [mammography]</td>
<td>Women ages 40 and over*</td>
</tr>
<tr>
<td>Breast-feeding counseling</td>
<td>Pregnant women</td>
</tr>
<tr>
<td>Cervical cancer screenings</td>
<td>All women regardless of age</td>
</tr>
<tr>
<td>Chlamydial infection screenings</td>
<td>All women regardless of age</td>
</tr>
<tr>
<td>Cholesterol screening</td>
<td>Men ages 35 and older</td>
</tr>
<tr>
<td></td>
<td>Women ages 45 and older</td>
</tr>
<tr>
<td></td>
<td>Men and women at risk for heart disease: ages 20 and over</td>
</tr>
<tr>
<td>Dental caries prevention</td>
<td>Infants and children up to age 5 years³</td>
</tr>
<tr>
<td>Depression screening, major depressive disorder</td>
<td>Adults, adolescents</td>
</tr>
<tr>
<td>Diabetes screening</td>
<td>Adults with sustained blood pressure of 135/80 mm hgl or greater</td>
</tr>
<tr>
<td>Falls prevention in older adults</td>
<td>Adults ages 65 and older at increased risk</td>
</tr>
<tr>
<td>Folic acid supplements</td>
<td>Women planning or capable of a pregnancy ages 10-50</td>
</tr>
<tr>
<td>Gestational diabetes mellitus screening</td>
<td>Pregnant women⁴</td>
</tr>
<tr>
<td>Gonorrhea screening</td>
<td>All sexually active women regardless of age</td>
</tr>
<tr>
<td>Gonorrhea, prophylactic eye medicine</td>
<td>Newborns (ages 0-6 months)</td>
</tr>
<tr>
<td>Hemoglobinopathies (sickle cell) screening</td>
<td>Newborns (ages 0-6 months)</td>
</tr>
<tr>
<td>Hepatitis B screening</td>
<td>Non-pregnant adolescents and adults at high risk⁵</td>
</tr>
</tbody>
</table>
## Preventive Coverage

<table>
<thead>
<tr>
<th>Service</th>
<th>Patient Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B screening</td>
<td>Pregnant women regardless of age</td>
</tr>
<tr>
<td>Hepatitis C virus infection screening</td>
<td>Adults(^6)</td>
</tr>
<tr>
<td>HIV screening</td>
<td>Adolescents and adults at increased risk</td>
</tr>
<tr>
<td>HIV screening</td>
<td>Pregnant women</td>
</tr>
<tr>
<td>Intimate partners violence screening</td>
<td>Women of childbearing age</td>
</tr>
<tr>
<td>Iron supplements</td>
<td>Children ages 6-12 months at increased risk for iron deficiency</td>
</tr>
<tr>
<td>Lung cancer screening(^7)</td>
<td>Adults ages 55-80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years</td>
</tr>
<tr>
<td>Obesity screening and counseling</td>
<td>Adults and children over age 6</td>
</tr>
<tr>
<td>Osteoporosis screening</td>
<td>Women ages 65 and over, age 60 if at increased risk</td>
</tr>
<tr>
<td>PKU screening</td>
<td>Newborns</td>
</tr>
<tr>
<td>Rh incompatibility</td>
<td>Pregnant women</td>
</tr>
<tr>
<td>Sexually transmitted infections (STIs) counseling</td>
<td>Sexually active adolescents, adults at increased risk</td>
</tr>
<tr>
<td>Skin cancer behavioral counseling</td>
<td>Children, adolescents and young adults ages 10 to 24</td>
</tr>
<tr>
<td>Syphilis screenings</td>
<td>People at increased risk, pregnant women</td>
</tr>
<tr>
<td>Tobacco use screening and intervention</td>
<td>Adults and pregnant women</td>
</tr>
<tr>
<td>Tobacco use interventions</td>
<td>Children and adolescents(^8)</td>
</tr>
<tr>
<td>Visual acuity</td>
<td>Children under age 5</td>
</tr>
</tbody>
</table>
For more information on ACA Benefits

- Visit our website and under Providers, see the Health Care Reform section.
- We will continue to add or update information as we get new regulations or further guidance from the federal government.
- Also visit www.ahealthysc.tv.
We cover preventive benefits at 100 percent for designated services the U.S. Preventive Services Task Force (USPSTF) outlines.

- Includes prostate screenings, pediatric vision care, health resources and health services administration

Individual plans do not have benefits for out-of-network providers.

- Benefits are for in-network providers only unless it is a true emergency
We cover children beginning at 0 years of age through the end of the benefit period of their 19th birthday.

Pediatric dental is no longer a benefit for 2015.

Copays, deductibles/coinsurance and a combination of all are integrated for formulary drugs.

All individual plans will be calendar year.
Benefit Overview

**ACA OOP**

- Medical, pediatric vision and drug copays/deductibles/coinsurance all feed the ACA OOP.
- When the ACA OOP is met, we cover benefits at 100 percent.
- Copays/deductibles/coinsurance all cease when the ACA OOP is met.

**Preauthorization**

- If a prior authorization is not received, individual plans will deny all benefits on certain services.

**BlueCard Processing**

- All plans have BlueCard coverage.
Health Insurance Marketplace (Exchanges): BlueCross Plans
BlueCross Exchange Plans: Small Group Plans

BlueEssentials℠ Business plans are a line of small group plans offered by BlueCross to businesses with 2-50 employees. These plans use the PPO Network.

**Alpha Prefixes**
- ZCV
- ZCR
- FFM

**Small Group Private**

**Preferred Blue Network**

**Member Name (NAME)**
- ZCV123456789999
- RxBIN: 004336
- RxGRP: SCB15
- Plan Code: 380
- Mammography Network

**www.SouthCarolinaBlues.com**
BlueCross Exchange Plans: Individual Plans

BlueEssentials℠ is a line of individual plans BlueCross offers.

- Two plan categories: metallic plans (Gold, Silver, Bronze) and Catastrophic plan.
- The network name indicates that the new exchange network is being used.
- These plans use the BlueCross Individual Exchange Network. Members do not have out-of-network benefits.

Alpha Prefixes

<table>
<thead>
<tr>
<th>Prefix</th>
<th>Plan Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZCU</td>
<td>Individual private</td>
</tr>
<tr>
<td>ZCF</td>
<td>Individual FFM</td>
</tr>
<tr>
<td>ZCQ</td>
<td>Individual FFM (multi-state plan)</td>
</tr>
</tbody>
</table>
2015 BlueEssentials Exchange Products

The open enrollment period for 2015 is November 15, 2014 through February 15, 2015.
# 2015 BlueEssentials Non-Commercial Products

<table>
<thead>
<tr>
<th>Benefit</th>
<th>BlueEssentials Gold 2 2015 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEDUCTIBLES</strong></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$800</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$1,450</td>
</tr>
<tr>
<td><strong>SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>$15 PCP, $40 Specialist</td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>Deductible then 70% coinsurance</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>Deductible then 70% coinsurance</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$300 copay, then deductible, then 70% coinsurance</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Deductible then 70% coinsurance</td>
</tr>
<tr>
<td><strong>COINSURANCE MAXIMUM</strong></td>
<td></td>
</tr>
<tr>
<td>Individual-Network</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family-Network</td>
<td>$7,450</td>
</tr>
</tbody>
</table>
# 2015 BlueEssentials Non-Commercial Products

<table>
<thead>
<tr>
<th>Benefit</th>
<th>BlueEssentials Silver 4 2015 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEDUCTIBLES</strong></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$1,900</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$3,450</td>
</tr>
<tr>
<td><strong>SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>$30 PCP, $50 Specialist</td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>Deductible, then 70% coinsurance</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>Deductible, then 70% coinsurance</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$300 copay, then deductible, then 70% coinsurance</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Deductible, then 70% coinsurance</td>
</tr>
<tr>
<td><strong>COINSURANCE MAXIMUM</strong></td>
<td></td>
</tr>
<tr>
<td>Individual-Network</td>
<td>$6,600</td>
</tr>
<tr>
<td>Family-Network</td>
<td>$12,050</td>
</tr>
</tbody>
</table>
# 2015 BlueEssentials Non-Commercial Products

<table>
<thead>
<tr>
<th>Benefit</th>
<th>BlueEssentials Bronze 3 2015 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEDUCTIBLES</strong></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$7,100</td>
</tr>
<tr>
<td><strong>SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>Deductible, then 80% coinsurance for PCP and specialist</td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>Deductible, then 80% coinsurance</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>Deductible, then 80% coinsurance</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Deductible, then 80% coinsurance</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Deductible, then 80% coinsurance</td>
</tr>
<tr>
<td><strong>COINSURANCE MAXIMUM</strong></td>
<td></td>
</tr>
<tr>
<td>Individual-Network</td>
<td>$6,350</td>
</tr>
<tr>
<td>Family-Network</td>
<td>$11,300</td>
</tr>
</tbody>
</table>
BlueCross Exchange Plans: Benefits and Features

To view the benefits and features of each BlueEssentials Plan, visit www.SouthCarolinaBlues.com.
Health Insurance Marketplace (Exchanges): BlueChoice Plans
BlueChoice Exchange Plans: Small Group Plans

Business Advantage Plans are a line of small group plans BlueChoice offers to businesses with 2-50 employees. These plans use the existing BlueChoice network.

Alpha Prefixes
- ZCL  Small Group Private
- ZCG  Small Group FFM
BlueChoice Exchange Plans: Individual Plans

• The new name for BlueChoice Exchange Individual Plans is Blue Option℠. It was formerly MyChoice Advantage.
• These plans use the BlueChoice Individual Exchange Network. Members do **not** have out-of-network benefits.

Alpha Prefixes
ZCX Individual FFM
ZCJ Individual Private
BlueChoice introduces the Blue Option website!

Take a moment to check out all of the available plans on www.BlueOptionSC.com.
2015 Blue Option Exchange Products

Each plan includes vision and preventive dental benefits for all members – not just children. The Open Enrollment period for 2015 is November 15, 2014 through February 15, 2015.
# 2015 Blue Option Non-Commercial Products

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Blue Option Gold 800 2015 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$800</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>$20 copayment for a PCP, $50 copayment for a specialist</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>$300 then deductible, then 30%</td>
</tr>
<tr>
<td>Services</td>
<td></td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Deductible, then 30%</td>
</tr>
<tr>
<td>Services</td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$300 then deductible, then 30%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Deductible, then 30%</td>
</tr>
<tr>
<td><strong>Coinsurance Maximum</strong></td>
<td></td>
</tr>
<tr>
<td>Individual-Network</td>
<td>$3,500</td>
</tr>
<tr>
<td>Family-Network</td>
<td>$6,700</td>
</tr>
</tbody>
</table>
### 2015 Blue Option Non-Commercial Products

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Blue Option Silver 400 2015 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$400</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$650</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>Deductible, then 50% coinsurance for PCP and specialist</td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>Deductible, then 50% coinsurance</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>Deductible, then 50% coinsurance</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Deductible, then 50% coinsurance</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Deductible, then 50% coinsurance</td>
</tr>
<tr>
<td><strong>Coinsurance Maximum</strong></td>
<td></td>
</tr>
<tr>
<td>Individual-Network</td>
<td>$6,350</td>
</tr>
<tr>
<td>Family-Network</td>
<td>$10,500</td>
</tr>
</tbody>
</table>
### 2015 Blue Option Non-Commercial Products

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Blue Option Bronze 6250HD 2015 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$6,250</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$10,850, non-embedded</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>Deductible for PCP and Specialist</td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>Deductible</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>Deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Deductible</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Deductible</td>
</tr>
<tr>
<td><strong>Coinsurance Maximum</strong></td>
<td></td>
</tr>
<tr>
<td>Individual-Network</td>
<td>$6,250</td>
</tr>
<tr>
<td>Family-Network</td>
<td>$10,850</td>
</tr>
</tbody>
</table>
Health Insurance Marketplace (Exchanges): Reminders
Transition of Care Form

We cover out-of-network providers for emergency care only.

- You should use a transition of care request for members who have an ongoing treatment plan at the time they are effective in a BlueEssentials or Blue Option plan and the provider currently providing treatment is not in the Individual Health Insurance Exchange Networks.

- It is not necessary to have a transition of care form for emergency coverage.
Transition of Care Form

We cover out-of-network providers for emergency care only.

- If a member has a condition for which they are under a physician’s care and they want to continue with that physician but the physician is not in the Individual Health Insurance Exchange Networks, you need a transition of care form.
- The member must complete the request prior to services.
Transition of Care Form

We cover out-of-network providers for emergency care only.

• You can find the form on our websites.
Please Note:

- Maternity benefits vary by plan. Some plans have a one-time copay for maternity care while others apply a deductible and coinsurance.
- The provider will bill global maternity the same as commercial.

Here is an example of a Blue Option plan with a maternity copay for professional care and a Blue Option plan that does not have a maternity copay for professional care.

<table>
<thead>
<tr>
<th>PLAN NAME</th>
<th>PRENATAL AND POSTNATAL CARE</th>
<th>DELIVERY AND ALL INPATIENT SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold 1000 (base plan)</td>
<td>$60 copay first visit</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>Silver 1500 (base plan)</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>
Covered Drug List

You can review our 2015 Covered Drug List for both BlueCross and BlueChoice Exchange plans on our websites.

Caremark handles prior authorization questions about:
• Step therapy
• Formulary exceptions
Policy Update to Precertification Requirement

These outpatient services require precertification:

<table>
<thead>
<tr>
<th>BlueCross Health Exchange</th>
<th>BlueChoice Health Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgeries</td>
<td>Outpatient surgeries</td>
</tr>
<tr>
<td>Outpatient therapies</td>
<td>Outpatient therapies</td>
</tr>
<tr>
<td>Outpatient infusion services</td>
<td>Outpatient infusion services</td>
</tr>
<tr>
<td></td>
<td>Dialysis</td>
</tr>
<tr>
<td></td>
<td>Nuclear stress tests</td>
</tr>
</tbody>
</table>
Utilization Management

- You must get prior authorization for certain services.
- Failure to get prior authorization may result in claim denial.
- Prior authorization is not a guarantee that we will cover the service.
- Benefits are subject to patient eligibility.
- Verify benefits and eligibility through My Insurance Manager from the BlueChoice or BlueCross website Provider section.
Utilization Management

• Types of service or treatment that must get preauthorization include:
  • Hospital admission, including maternity notifications
  • Skilled nursing facility (SNF) admission
  • Continuation of a hospital stay (remaining in the hospital or SNF for a period longer than was originally approved) for a medical condition
  • Outpatient chemotherapy or radiation therapy
  • Outpatient hysterectomy or septoplasty
  • Home health care or hospice services
  • Durable medical equipment when the purchase price or rental is $500 or more
Utilization Management

- Types of service or treatment that must get preauthorization include:
  - Admissions for habilitation, rehabilitation and/or human organ and/or tissue transplants
  - Treatment for hemophilia
  - Mental health and substance use disorders
Utilization Management

• Other types of service or treatment that must get preauthorization:
  • Certain prescription drugs and specialty drugs
    • Caremark handles prior authorization for these treatments
  • Advanced radiological services
    • NIA handles prior authorization for these services.
Utilization Management: Cosmetic Procedures

- Any procedure that is considered cosmetic is a non-covered service.
- Examples include:
  - Blepharoplasty
  - Vein surgery
  - Sclerotherapy
  - Reduction mammoplasty
  - Brow lifts
  - Rhinoplasty
Hospitals in the BlueCross and BlueChoice Individual Health Insurance Exchange Networks effective January 1, 2015

Gray = No Hospitals are located in the County
Blue = Location of contracted Hospital
Thank You!
Stay Tuned for More!

We appreciate our provider community for working together to improve the lives of our members.

Look for 2015 educational opportunities:
★ Regional workshops
★ Webinars
★ And much, much more!