Healthy Blue℠

BlueChoice® HealthPlan of SC

Healthy Connections

Provider Orientation

October 2025

Welcome to the Healthy Blue Network

We are excited to welcome you as a valued partner in delivering high-quality, accessible health care to our members. Your participation plays a vital role in ensuring our communities receive the care they deserve.

At Healthy Blue, we're dedicated to building strong, supportive relationships with our providers built on collaboration, respect, and open communication. Together, we can make a real difference in the health of those we serve.

Thank you for joining us—we look forward to partnering with you and providing the tools and resources you need to deliver excellent care.

Topics of Discussion

- Provider Responsibilities
- Member Rights and Responsibilities
- Being a Self-servicing Provider
  - Website Content
  - My Insurance Manager℠
  - My Remit Manager
  - My Provider Enrollment Portal
- Overview of Member Benefits
  - Benefit Partners
  - Provider Incentives
  - Behavioral Health
- Authorizations
- Claims
- Mental Health Stigmas
- Provider Education and Training
- Contacts and Resources

Provider Responsibilities

Access Standards for Providers

Healthy Blue requires providers to make appointments for members from the time of request consistent with written scheduling procedures. Be mindful that wait times should not exceed 45 minutes.

- **Primary care providers (PCP), OB/GYNs and Autism Therapy**
  - **Routine visit: Available within 15 business days**
  - Urgent, non-emergent visit: Available within 48 hours
  - Emergent visit: Available immediately upon presentation at a service delivery site
- **Specialists**
  - Routine visit: Available within four weeks and maximum of 12 weeks for unique specialists
  - Urgent medical condition care visit: Available within 48 hours of referral or notification from PCP
  - Emergent visit: Available immediately upon referral
- **Behavioral Health**
  - Routine visit: Available within 10 business days
  - **Follow-up visit for routine care: Available within 15 days of initial visit**
  - Urgent, non-emergent exam visit: Available within 48 hours of request
  - **Emergent (non-life threatening) visit: Available immediately upon presentation at a service delivery site**

Note: Bolded items became effective July 1, 2025.

PCP Scope of Responsibilities

Healthy Blue members select a contracted primary care provider (PCP) as their main provider of health care services within the established period of the effective date of enrollment.

If, after the established period of the effective date of enrollment, the member has not selected a PCP, Healthy Blue assigns a PCP to the member.

PCPs can be general practitioners, family practitioners, internists, OB-GYNs or pediatricians who are chosen or designated for each member and are responsible for coordinating the health care of the member, including necessary referrals to other providers. The PCP's scope of practice includes the development and oversight of the member's treatment and care plan, including availability to health care 24/7. The PCP serves as the primary provider of a member's health care services.

Note: Review the Provider Office Manual for a full list of responsibilities.

Specialist Scope of Responsibilities

Specialist physicians, licensed with additional training and expertise in a specific field of medicine, supplement the care given by PCPs. Access to contracted network specialists is done through the member's PCP. In limited cases, such as family planning and evaluation or in the diagnosis, treatment and follow-up of sexually transmitted diseases (STDs), the member can self-refer.

PCPs refer members to Healthy Blue-contracted network specialist physicians for conditions beyond the PCP's scope of practice that are medically necessary. Specialists diagnose and treat conditions specific to their areas of expertise. Specialist care is limited to Healthy Blue benefits.

We require specialist physicians acting as PCPs to follow the processes listed in the PCP Scope of Responsibilities section. Members with disabling conditions or chronic illnesses or those who are under age 21 with special health care needs can request that their PCPs be specialists. We require specialist physicians acting as PCPs to follow all responsibilities of a PCP.

Note: Review the Provider Office Manual for a full list of responsibilities.

Hospital Scope of Responsibilities

PCPs refer members to Healthy Blue-contracted network hospitals for conditions beyond the PCP's scope of practice that are medically necessary. We limit payment for hospital care to Healthy Blue benefits. Hospital professionals diagnose and treat conditions specific to the area of expertise.

Note: Review the Provider Office Manual for a full list of responsibilities.

Ancillary Scope of Responsibilities

Healthy Blue has a network of various participating health care professionals and facilities. Health care professionals provide medically necessary services when a licensed physician or licensed health care professional orders the services and are in accordance with the applicable benefit agreement and Ancillary Agreement. All services the health care professional provides, and for which the health care professional is responsible, are listed in the Ancillary Agreement. We require health care professionals to agree that all medical services they provide or arrange are included in the rates, as described in the Ancillary Agreement.

Note: Review the Provider Office Manual for a full list of responsibilities.

Fraud, Waste and Abuse

- If you suspect the act of fraud, waste or abuse, you have a responsibility and a right to report it. You also have the right to remain anonymous when reporting fraud, waste and abuse.
- Find out as many details as you can before reporting fraud, waste, or abuse.
- Here are ways to report fraud, waste or abuse to us:
  - Call the BlueCross BlueShield of South Carolina Fraud Hotline toll-free at 800-763-0703.
  - Use the form on this website: www.SouthCarolinaBlues.com/web/public/brand/sc/assistance/report-fraud/
  - Fax the form to our anti-fraud unit at 803-870-8356.
  - Write to us:

    BlueCross BlueShield of South Carolina Anti-Fraud Unit
    Mail Code: AC-200
    P.O. Box 24011
    Columbia, SC 29224-4011
  - You may also call or email the South Carolina Medicaid Fraud Hotline:
    - 888-364-3224
    - fraudres@scdhhs.gov

Details Required to Report Fraud, Waste and Abuse

- When you report fraud, waste or abuse, give all necessary details:
  - Name, address and phone number of the provider
  - Name and address of the hospital, nursing home or home health agency
  - Medicaid number of the provider and place if applicable
  - Type of provider
  - Names and phone numbers of other people who can provide details
  - Dates of events
  - A brief statement of what has occurred
- When you report someone who receives benefits, please ensure to have the following details:
  - The person’s name
  - The person’s date of birth and social security number if you know it
  - The city where the person lives
  - Explanation of fraud, waste and abuse

Cultural Competency

- Cultural competency is a set of congruent behaviors, attitudes and policies that enable effective work in cross-cultural situations.
- Being culturally competent means that you are culturally aware and possess the ability to recognize norms, cultural factors, values, communication patterns and socioeconomic status. All these things help to shape a person personal and professional behavior.
- Once you become culturally competent, you acquire certain skills that assist you with providing the best service to your patients. Below are some of these skills.
  - Listen in an unbiased manner.
  - Consider cultural differences.
  - Recognize the importance of culture.
  - Understand the importance of diversity.
  - Use appropriate methods for interaction.

Note: Review more details by visiting the Improving Patient Experience page of our website. Providers>Patient Care>Improving Patient Experience

Member Rights and Responsibilities

Provider Awareness

- Physicians and other health care providers should be aware of the member's rights and responsibilities.
- While a full list of their rights and responsibilities are included in the Provider Office Manual, a portion includes:
  - Rights
    - Being treated with respect and regard for their dignity and privacy
    - Taking part in decisions about their health
    - Refusing care or treatment
  - Responsibilities
    - Showing their identification cards at each visit
    - Keeping and being on time for doctor visits
    - Treating their PCP and staff with respect

Being a Self-servicing Provider

Self-service Provider Tools

We offer a variety of self-service provider tools designed to make your work easier, faster and more efficient. These include:

- My Insurance Manager
- My Remit Manager
- My Provider Enrollment Portal

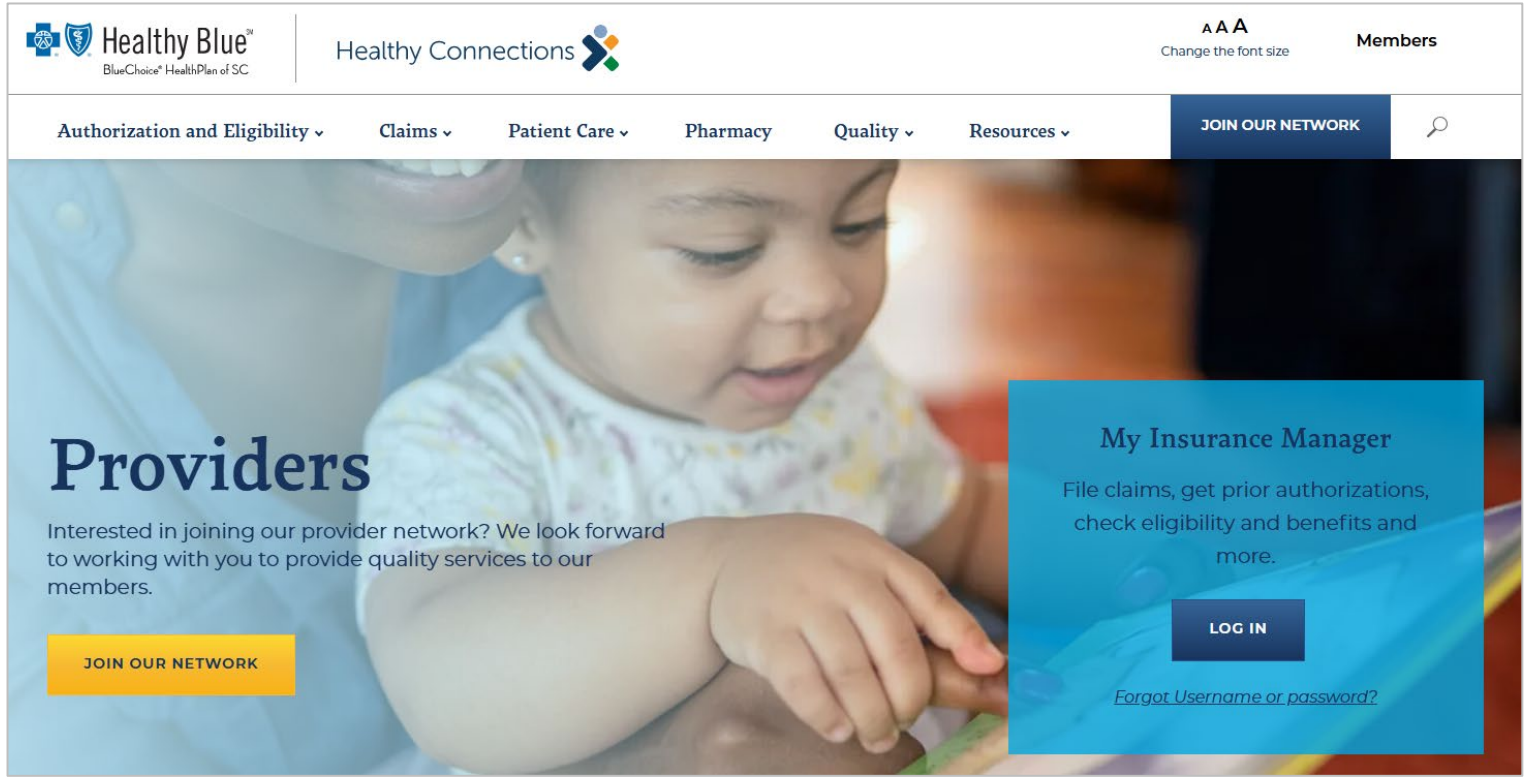
With these tools, you can access the information you need—such as member eligibility and benefits, claims status, remittance details, and even complete provider enrollment or maintenance requests—all in one convenient place.

Most times, these tools are available to your 24/7, giving you the flexibility to manage tasks on your own schedule and the confidence of knowing the information is always at your fingertips. Occasionally, the systems may be down temporarily for routine maintenance.

Website Content

Provider Website

- www.HealthyBlueSC.com
- Information you can find includes:
  - Authorization and Eligibility
  - Claims
  - Patient Care
  - Pharmacy
  - Quality
  - Resources
  - And much more!

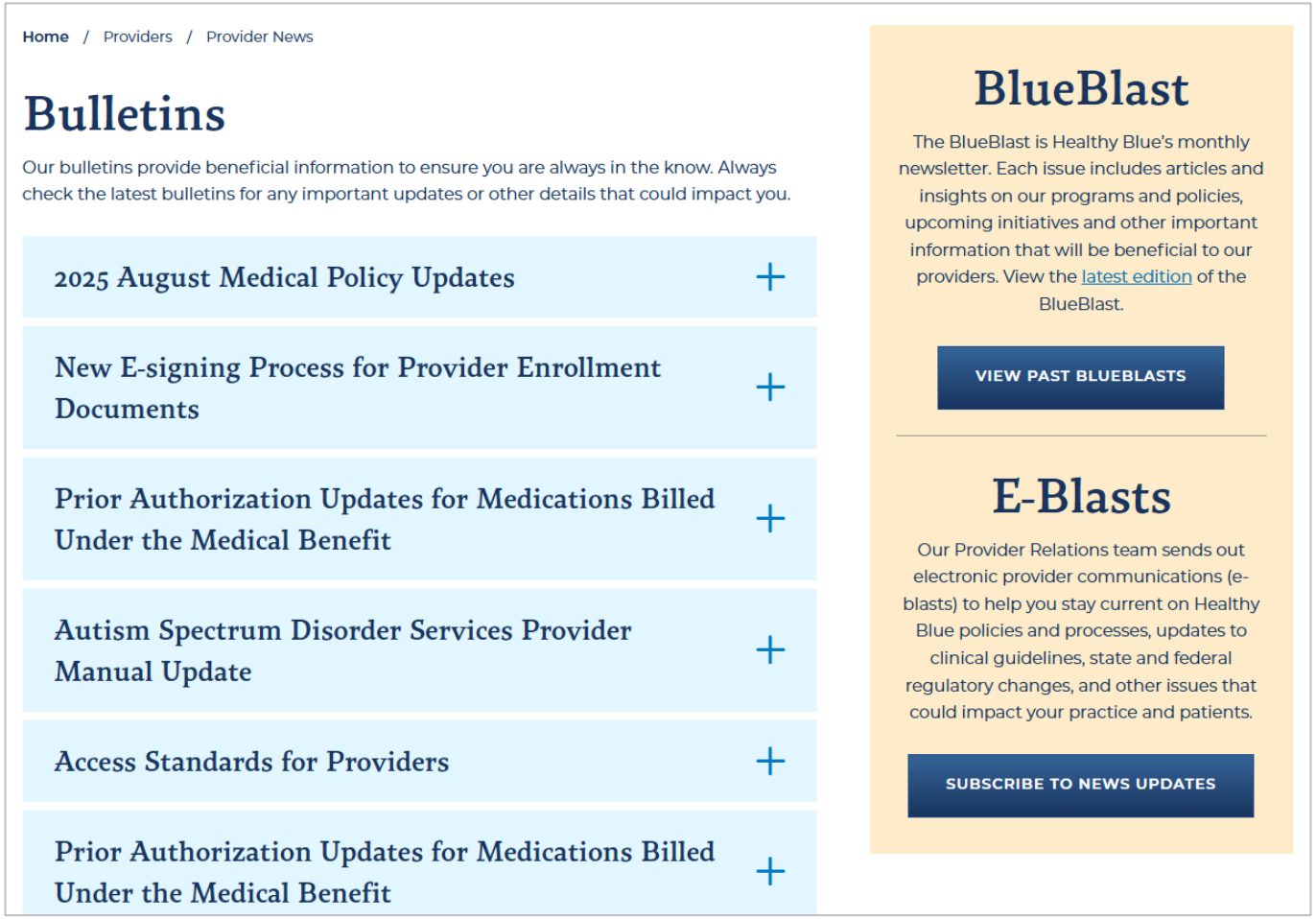


Webinars and Workshops

- To ensure you are always in the know, we host webinars, workshops and other events that will keep you abreast of any important initiatives or changes taking place.
- Under the Provider Education section of the website, you will see all the upcoming events and can easily register to attend.

Bulletins, Newsletters, and E-Blasts

- We communicate with the provider community in several ways, some of which include:
  - Bulletins
  - BlueBlast (monthly newsletter)
  - E-Blasts (electronic notifications)
- Go to the Provider News section of the website to view the latest information and to sign up to receive electronic notifications.



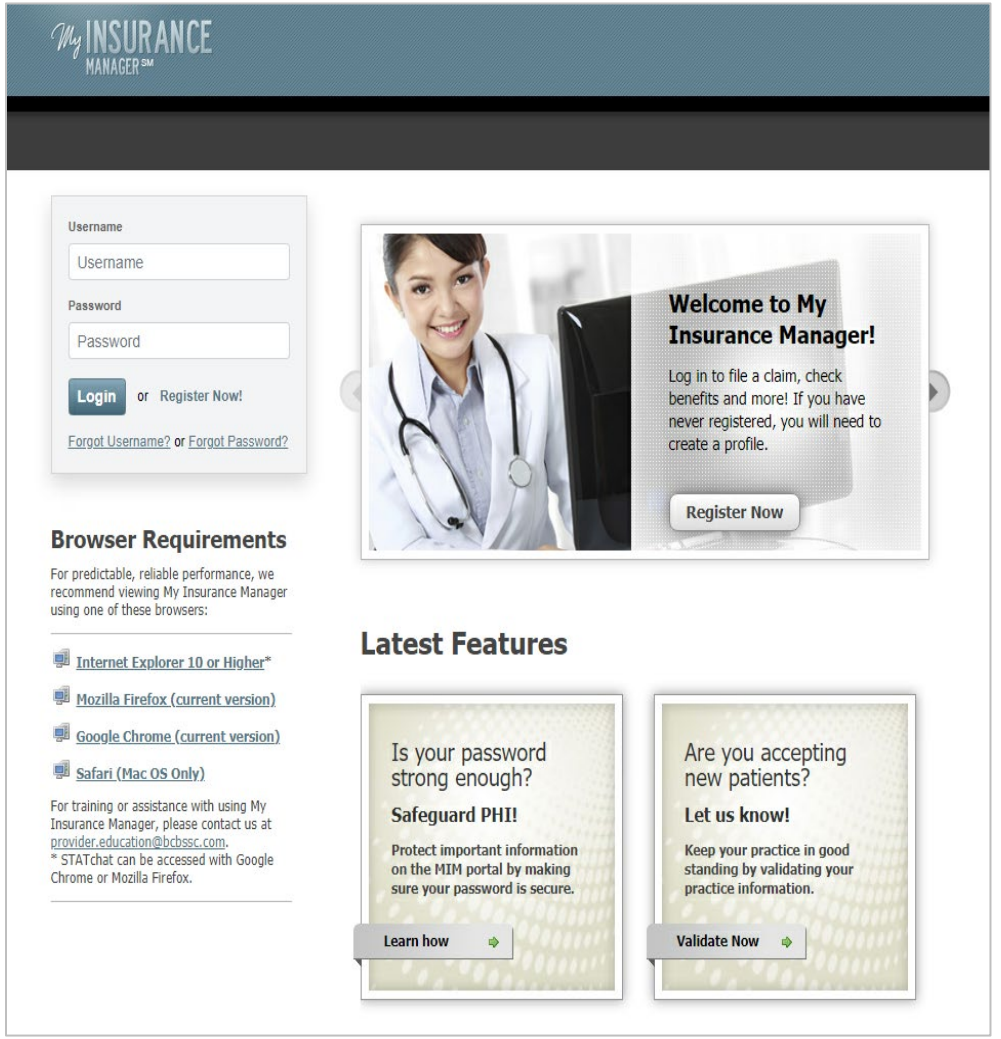
My Insurance Manager

Overview of My Insurance Manager

- My Insurance Manager is a web-based tool used to check eligibility, benefits, claim status, get prior authorizations and much more.
- The following guides are available under the Resources section of the Healthy Blue website:
  - Getting Started
  - Eligibility and Benefits
  - Claims Entry
  - Claims Status, Patient Directory, Superbill Maintenance and Coordination of Benefits
  - Precertification, Pre-Treatment Estimate for Authorization Status
  - Office Administration
  - Provider Validation: M.D. Checkup

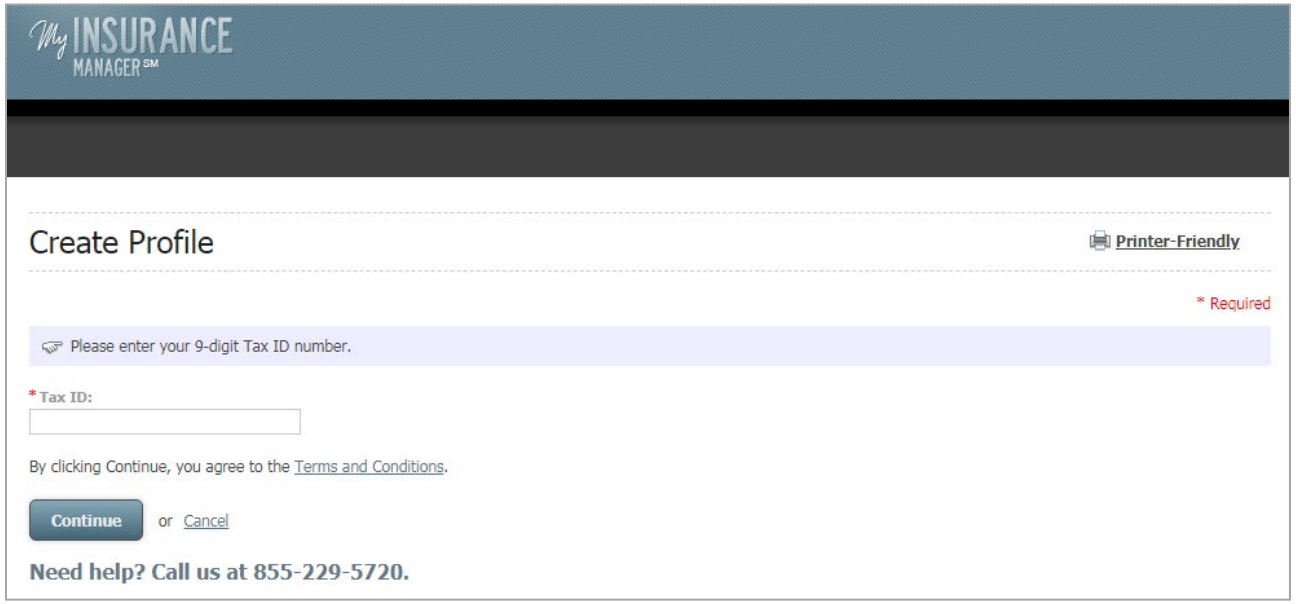
Getting Started with My Insurance Manager

- Visit the Healthy Blue website and select Providers.
- You will have the option to access My Insurance Manager from several pages under the Provider section.
- If you do not already have an account for My Insurance Manager, from the home page of the portal, select Register Now.



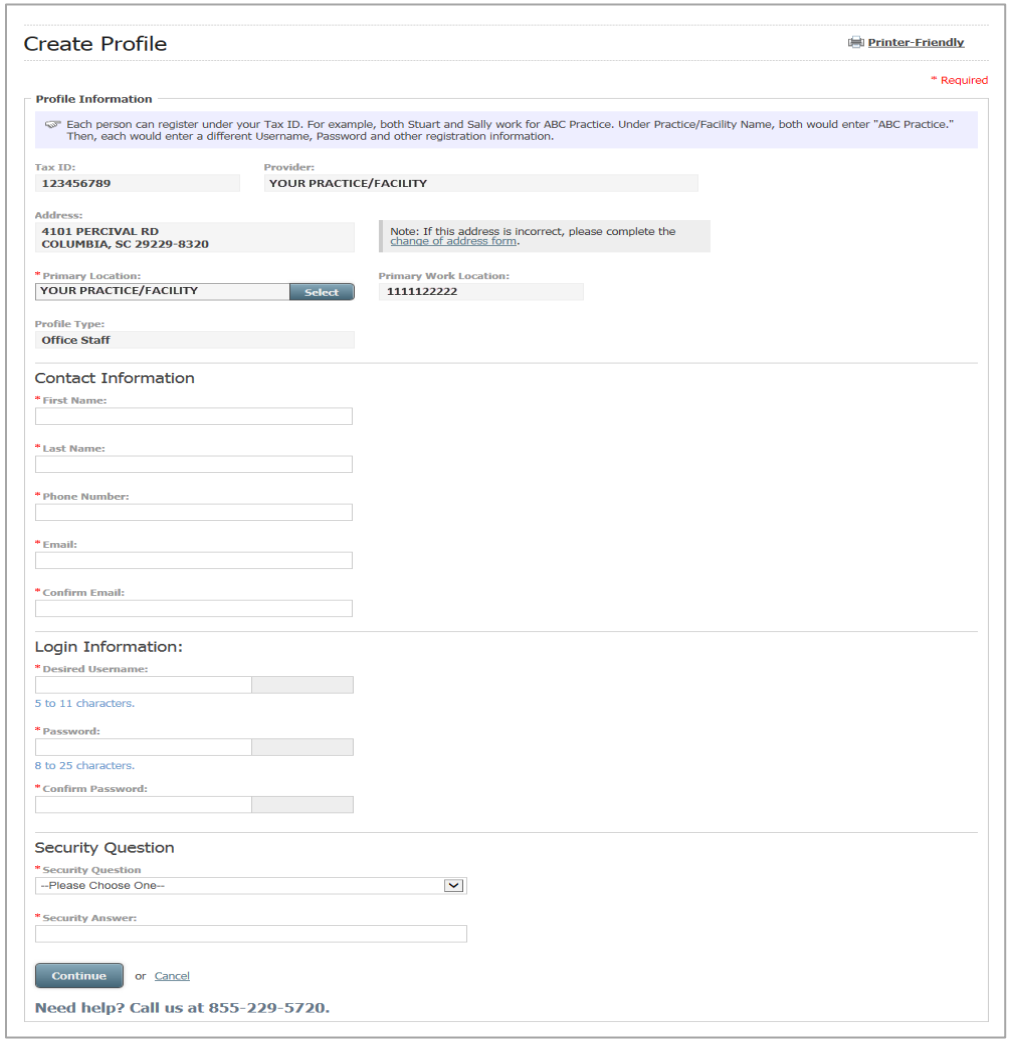
Creating a Profile in My Insurance Manager

- To create a profile in My Insurance Manager, you must have a 9-digit tax identification number (TIN).
- Enter the TIN in the appropriate field and select Continue.
- If you run into any technical issues, contact our technical support team at 855-229-5720.



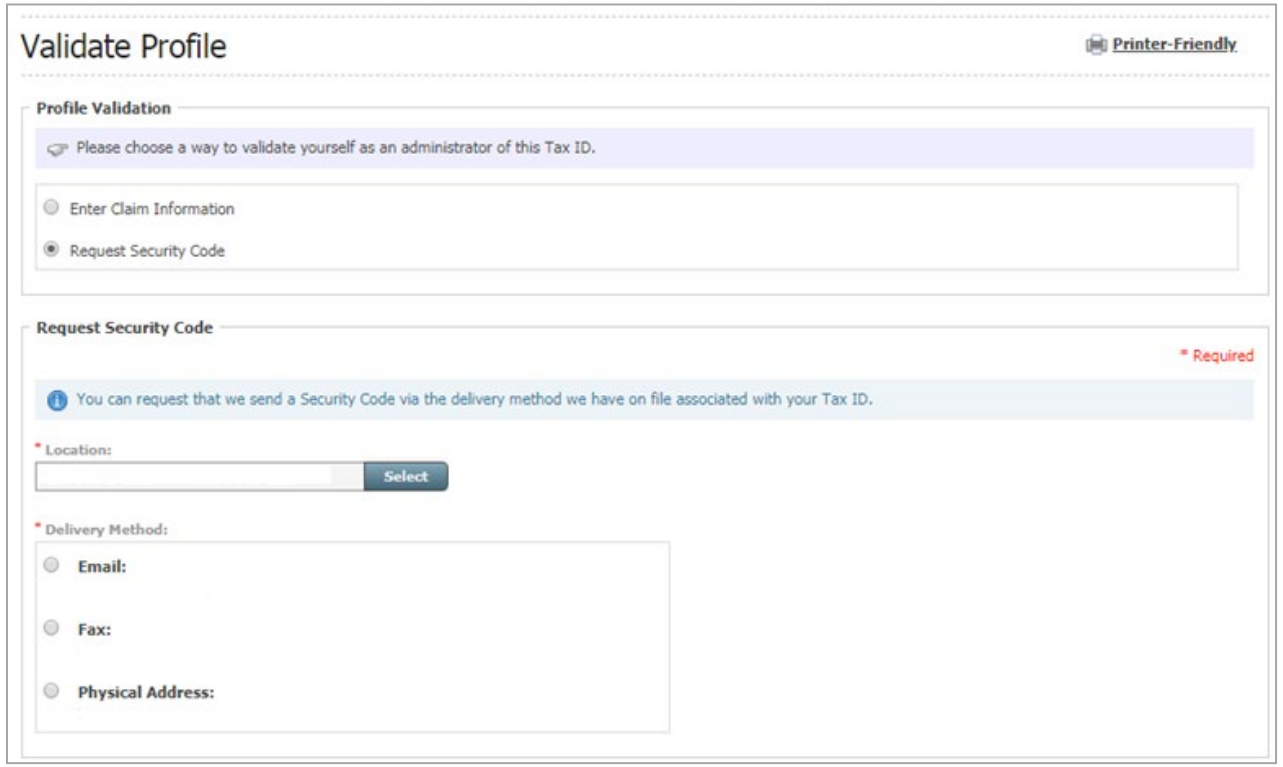
Profile Information

- The information associated with the Tax ID will pre-populate.
  - If there are multiple locations for the practice, you will be given the option to select the primary location.
- Enter the remaining contact and login information.
- Select a security question and include the answer.
- Select Continue.



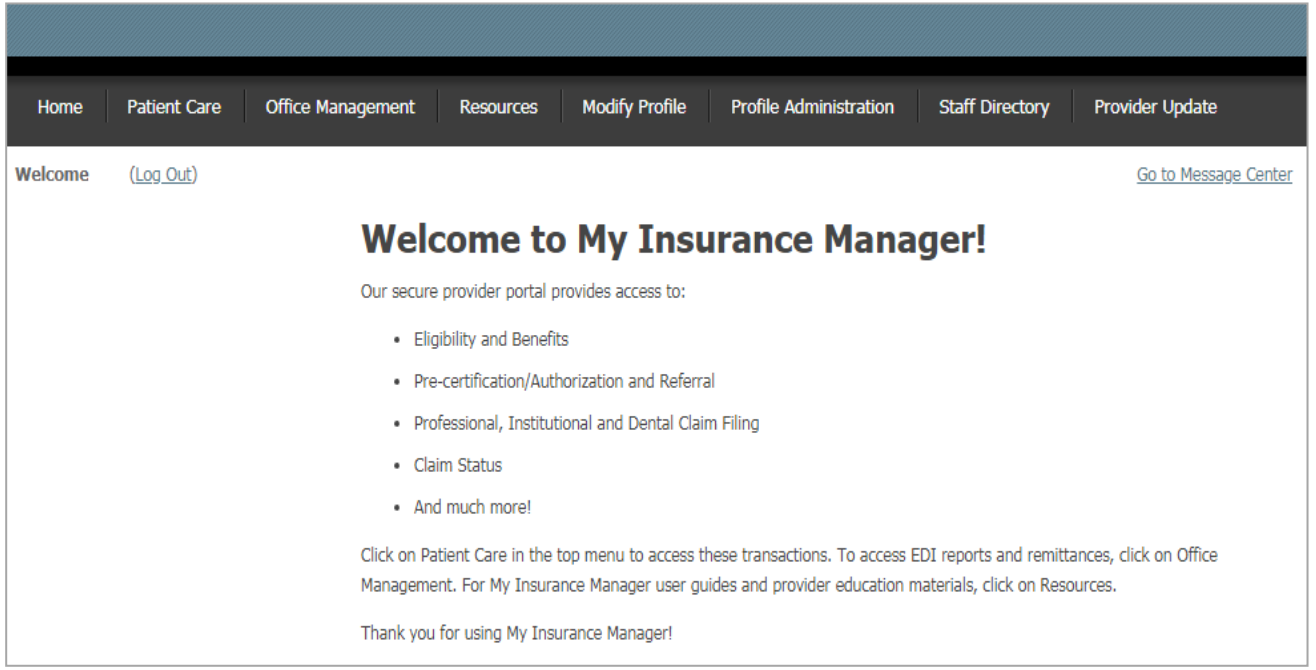
Validating Profile

- If registering as the profile administrator, you must validate your profile by entering claim information or requesting a security code (recommended). Also, choose the delivery method for the code.
- After completing registration, it can take up to two business days for the profile to be approved.
  - If the practice already has a profile administrator, they must review and approve profile requests.
- When the profile is approved, use your username and password to log in.



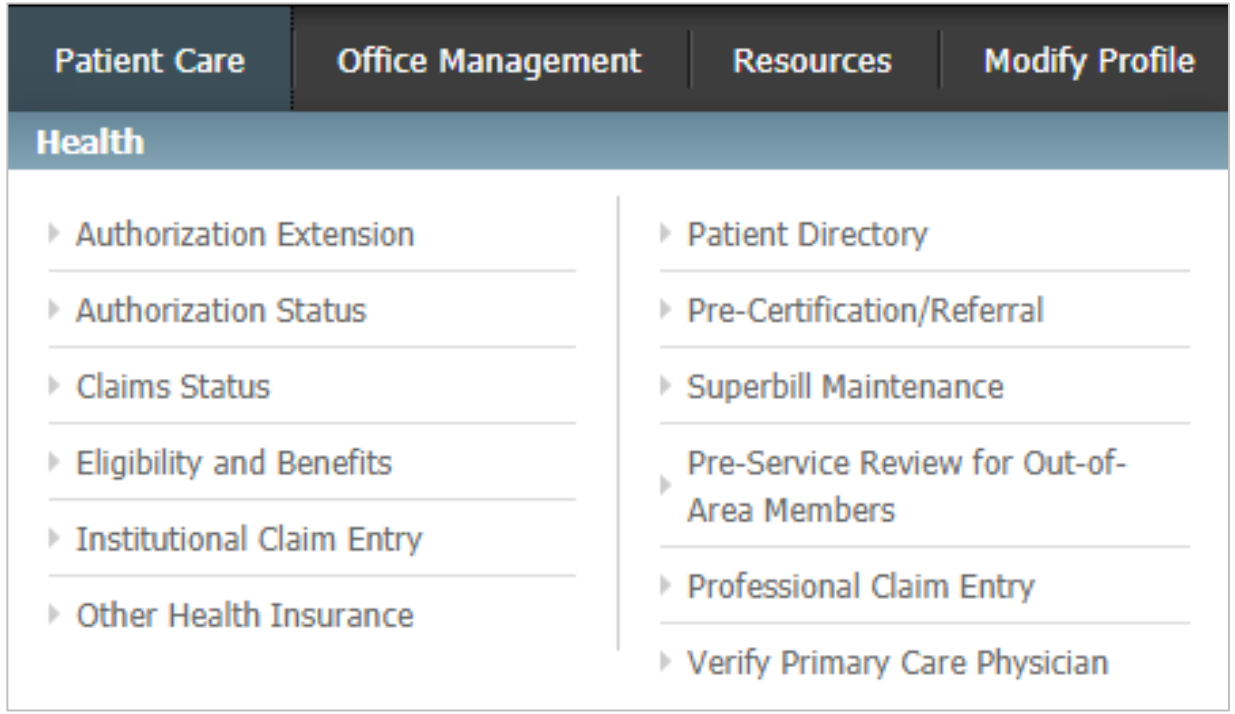
Navigational Options

- The following administrative tabs are located at the top of the home page:
  - Patient Care
  - Office Management
  - Resources
  - Modify Profile
  - Profile Administration
    - Only available for administrators
  - Staff Directory
  - Provider Update (M.D. Checkup)



Patient Care

- There are several options available under Patient Care. Some of the most common requests include:
  - Claims Status
  - Eligibility and Benefits
  - Institutional or Professional Claim Entry
  - Pre-certification/Referral



Office Management

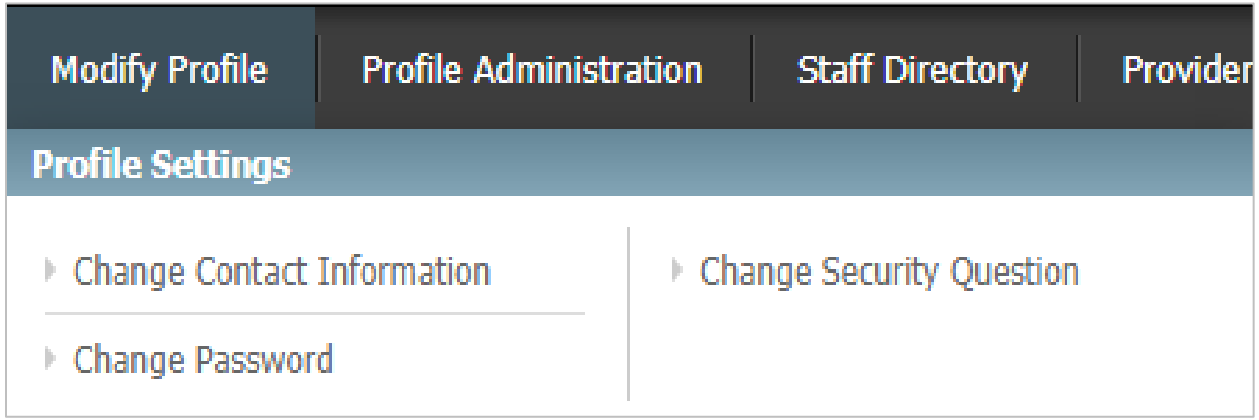
- There are several options available under Office Management. Some of the most common requests include:
  - EDI Reports
  - Remittance Information
  - Refund Letters
  - HEDIS® Quality Reports

Resources

- There are several options available under Resources. Some of the most common requests include:
  - Find Care
  - Medical Policies
  - My Remit Manager

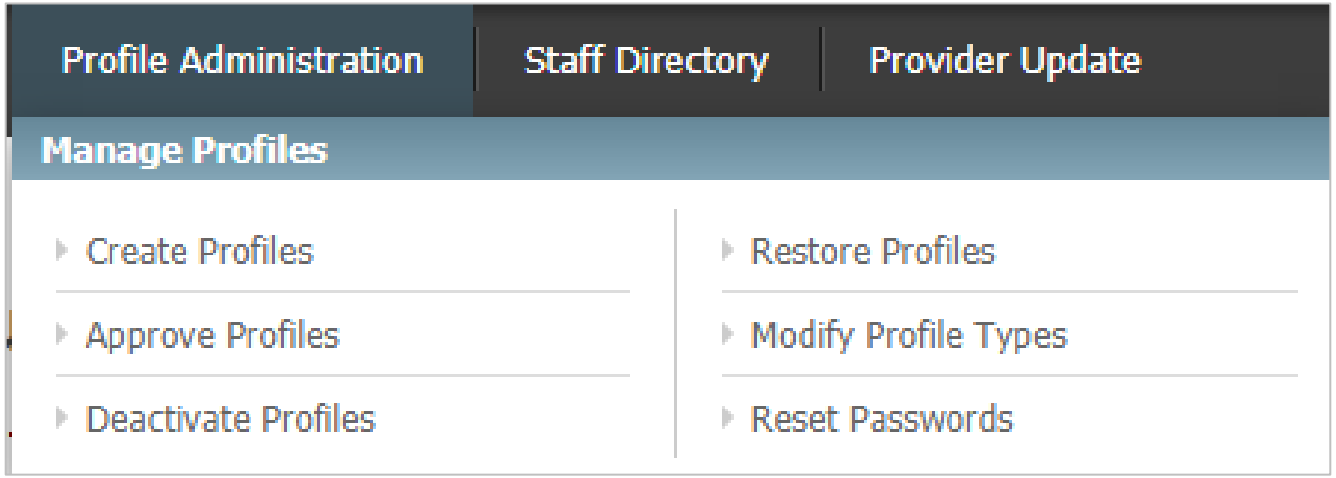
Modify Profile

- Modify Profile gives the user three options related to their profile settings:
  - Change Contact Information
  - Change Password
  - Change Security Question



Profile Administration

- Only the profile administrator for the practice will have this tab. The administrator can manage the following options for profiles:
  - Create Profiles
    - Create individual profiles for staff members.
  - Approve Profiles
    - Approve profiles that were created by staff members.
  - Deactivate Profiles
    - Close profiles for staff members that no longer work for the practice.
  - Restore Profiles
    - Restore profiles that were deactivated.
  - Modify Profile Types
    - Change a profile type from staff member to profile administrator and vice versa.
  - Reset Passwords
    - Reset password for staff members.



Staff Directory

- The staff directory simply shows a list of profiles associated with the TIN.

Provider Update

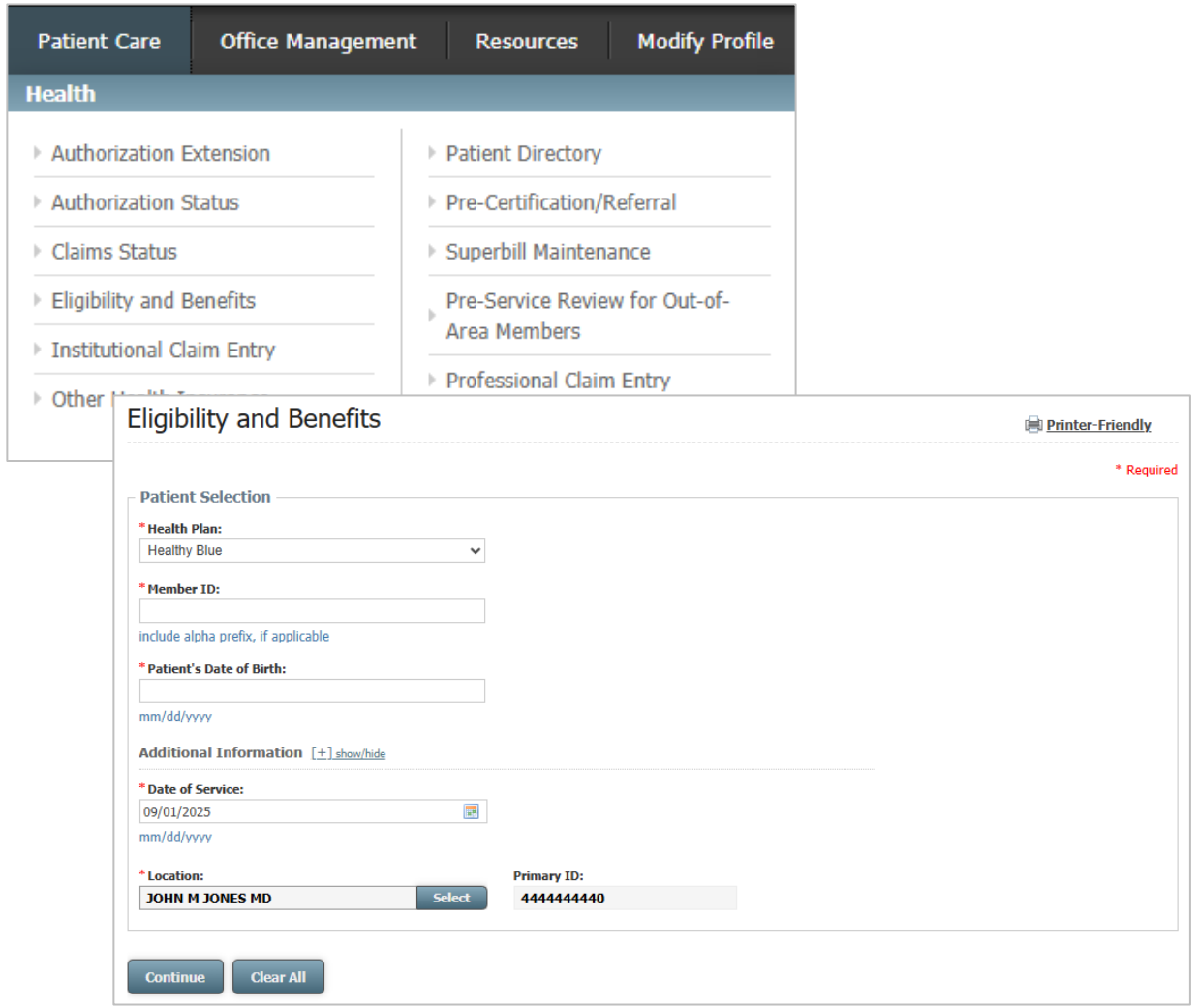
- Providers are required to verify their demographic data at least every 90 days as part of the No Surprises Act implemented on Jan. 1, 2022.
- Validation allows us to maintain accurate provider directories.
- Verification can be completed using Provider Update (M.D. Checkup).
  - You can also respond to the email received from Provider.Directory@bcbssc.com.

Troubleshooting Tips for My Insurance Manager

- Complete the registration process to avoid limited access.
  - If credentialing is pending, be sure to wait until you receive confirmation that it is completed.
- Use one of the recommended browsers:
  - Internet Explorer 10 or higher
  - Mozilla Firefox
  - Google Chrome
  - Safari
- On Sundays, the portal is unavailable for maintenance from 5 p.m. to midnight.

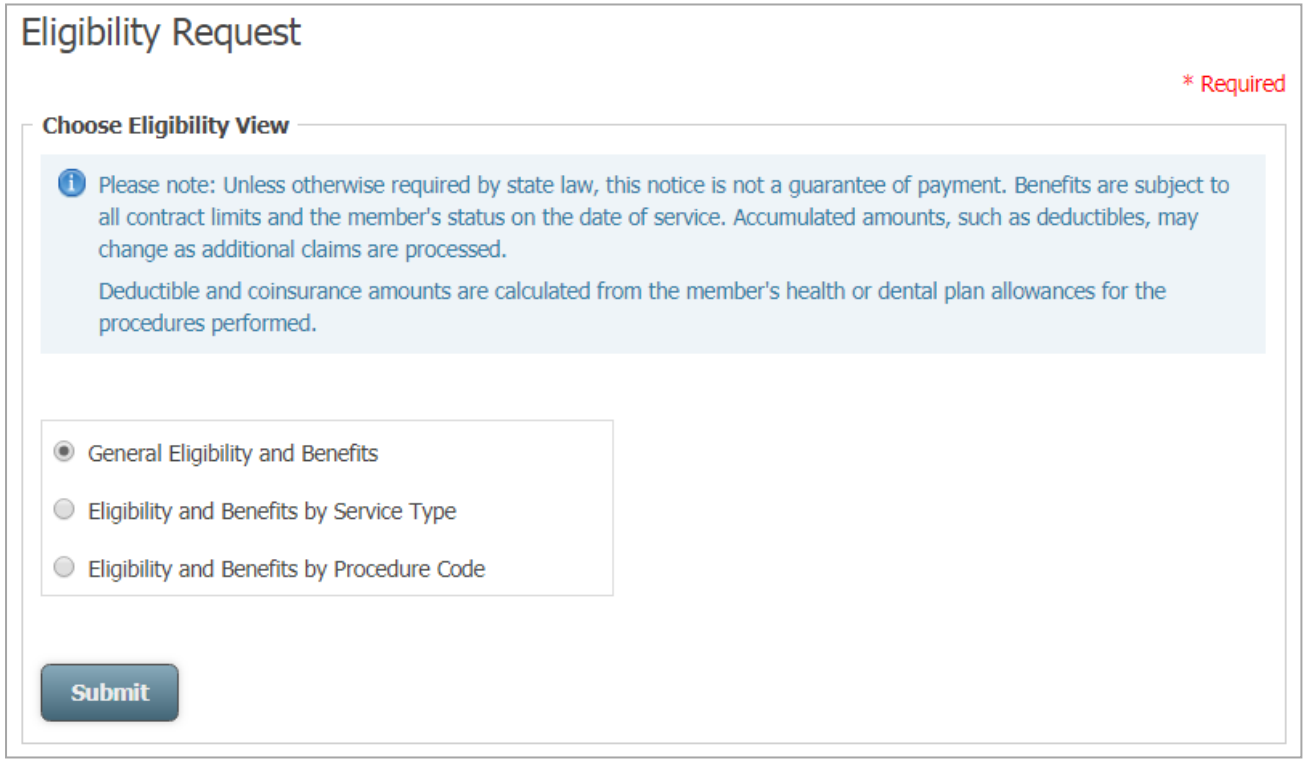
How to Check Benefits

- Under Patient Care, select Eligibility and Benefits.
- On the next screen, select Healthy Blue for the Health Plan, and enter the remaining details.
- Select Continue.



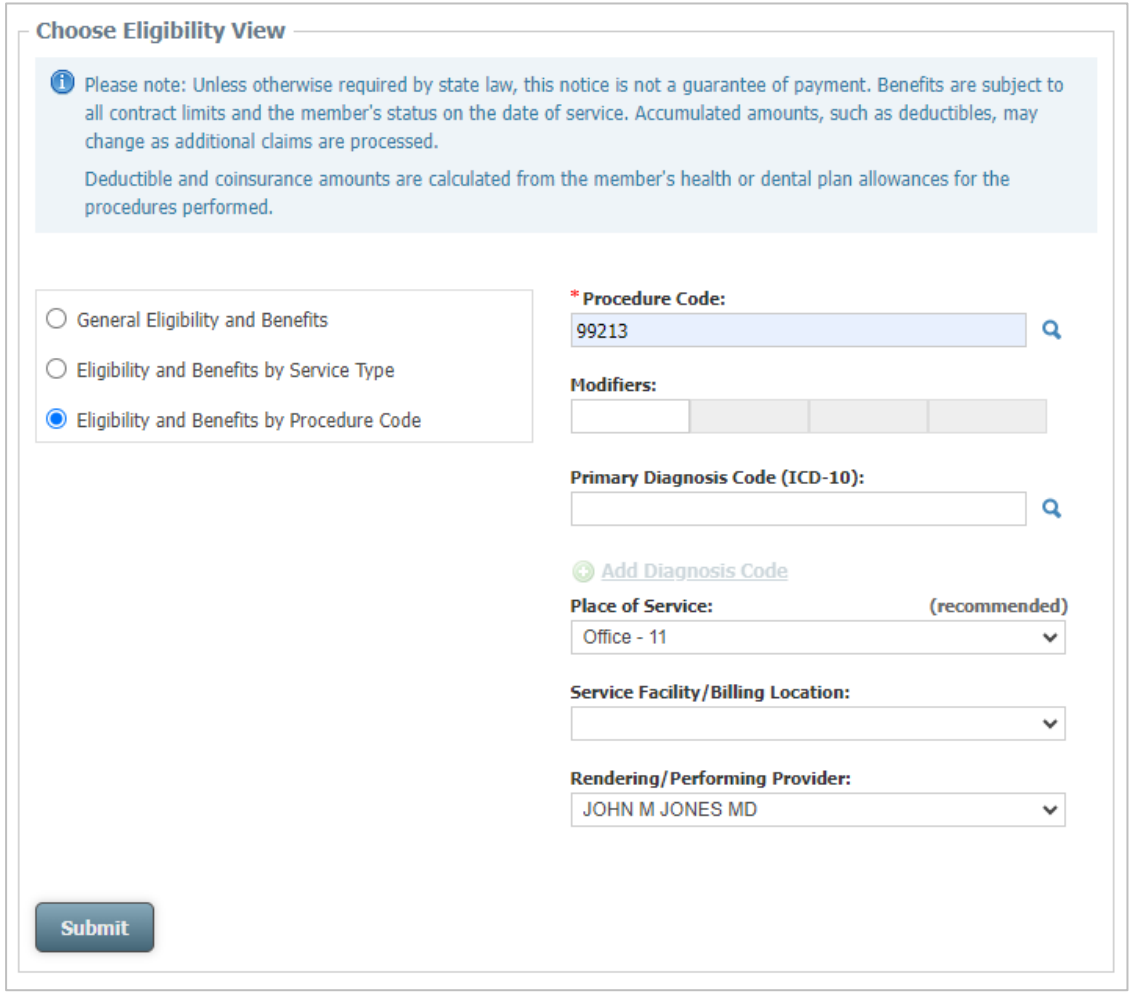
Available Benefit Options

- The following options are available when checking benefits:
  - General Eligibility and Benefits
    - Will pull general coverage details (i.e., office visit, inpatient care, outpatient hospital, etc.)
  - Eligibility and Benefits by Service Type
    - Will pull general coverage details based on a specific service type selected (i.e., allergy services, physical therapy, etc.)
  - Eligibility and Benefits by Procedure Code
    - Recommended option
    - Will pull specific coverage details based on the procedure code entered
    - You can also include diagnosis codes and modifiers if available



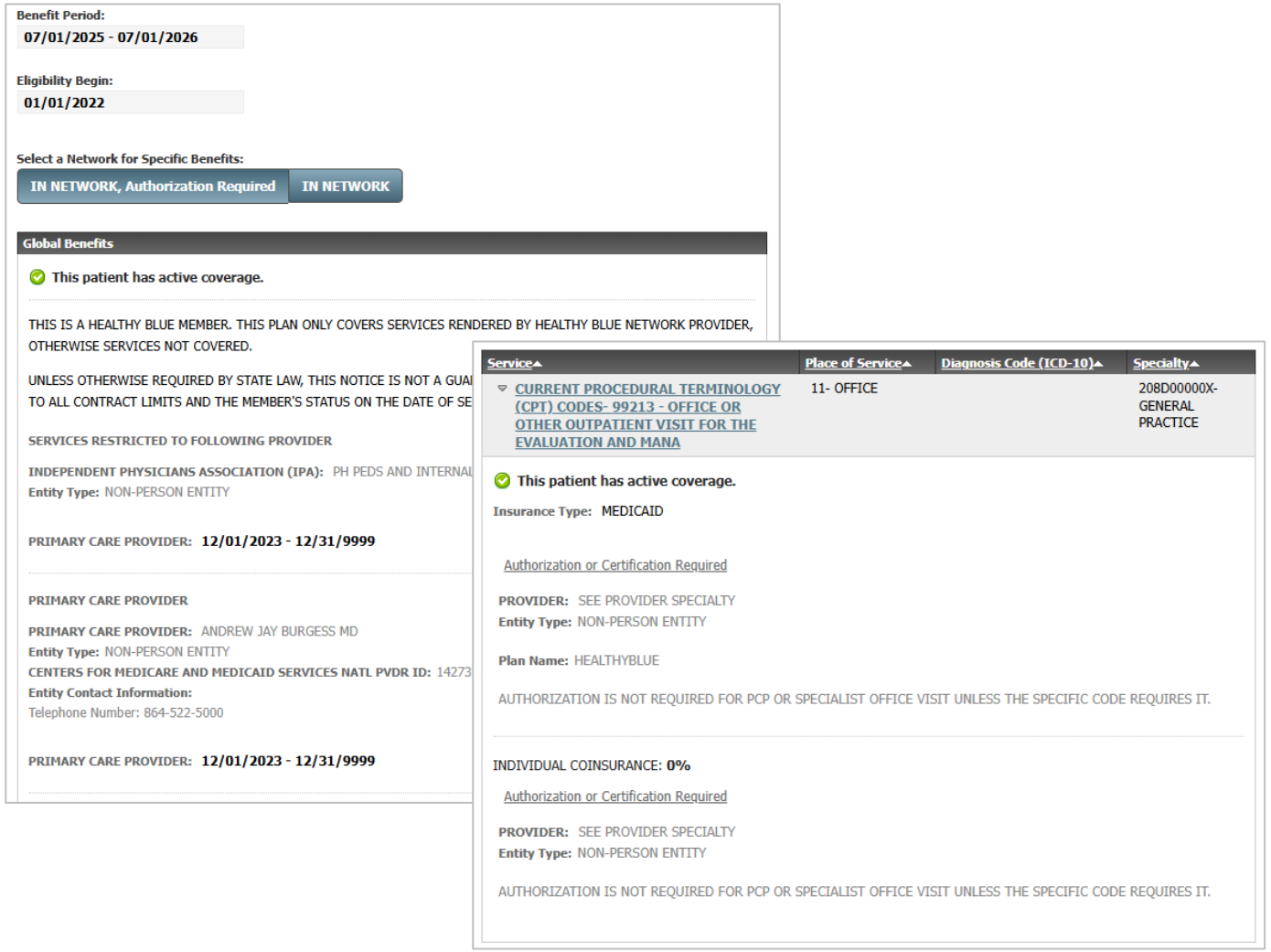
Getting Benefits Using a Procedure Code

- From the Choose Eligibility View page, select Eligibility and Benefits by Procedure Code.
- Enter the procedure code.
- Enter any applicable modifiers or diagnosis codes.
- Select the place of service.
- The service facility and rendering provider details will prepopulate based on your TIN and previous location selection.
- Select Submit.



Benefit Results

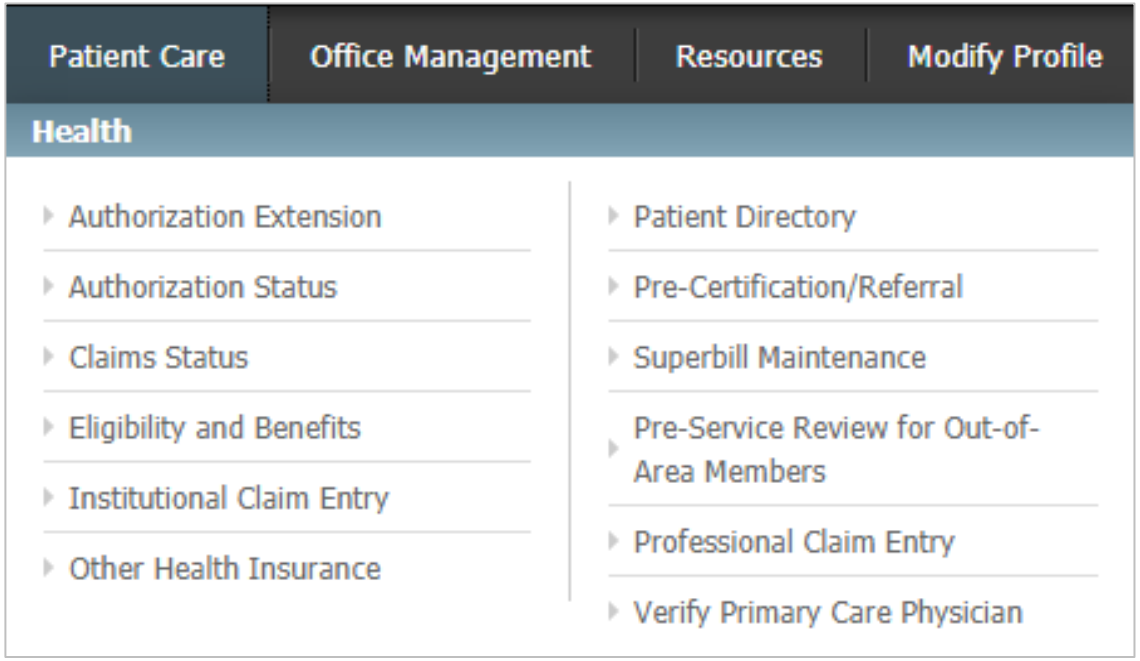
- You will receive the following results:
  - Benefit period
  - Eligibility begin date
  - Global coverage details
  - PCP
  - Benefit for procedure code entered



Note: You can also refer to the available fee schedules and manuals on www.scdhhs.gov for additional details.

Submitting Claims

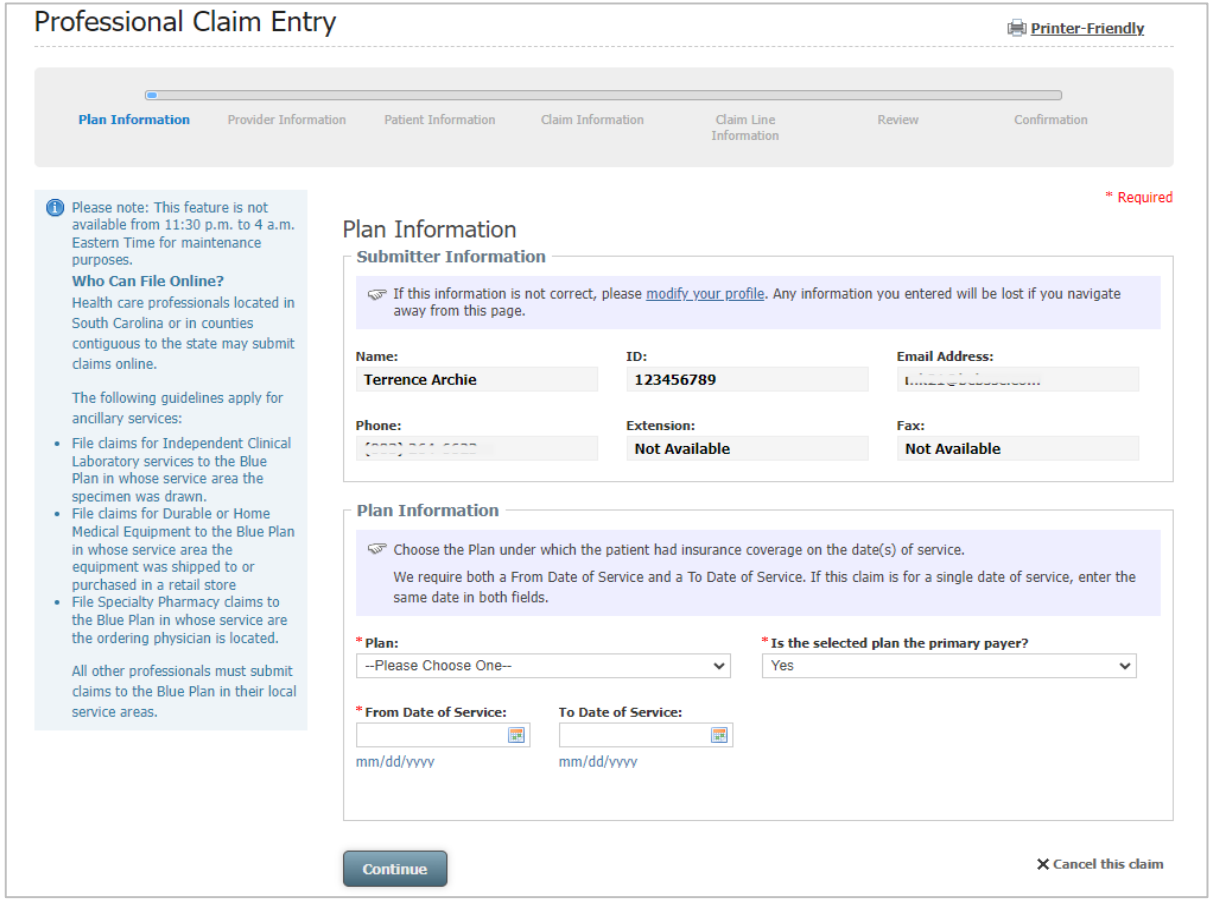
- Under Patient Care, select Institutional Claim Entry or Professional Claim Entry.
- You will progress through the following screens:
  - Plan Information
  - Provider Information
  - Patient Information
  - Claim Information
  - Claim Line Information
  - Review
  - Confirmation



Note: You would use these options when you cannot get your claims to go through your clearinghouse.

Plan Information for Claim Entry

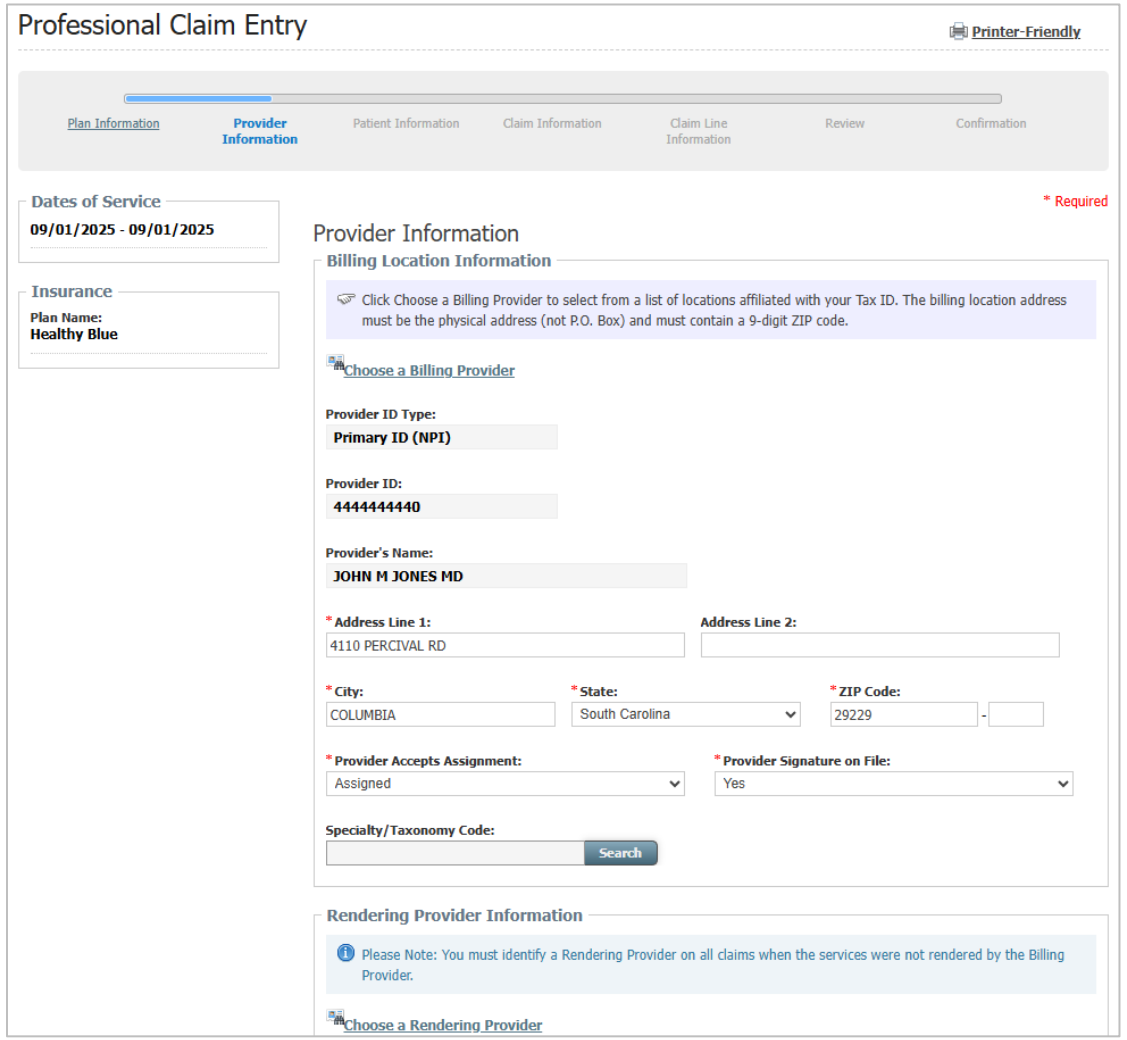
- For the plan information section, the submitter details will prepopulate based on your login details.
- You must select Healthy Blue for the plan type and include the remaining required details.
- Select Continue.



Note: At any time, you can select Cancel this claim to end the process.

Provider Information for Claim Entry

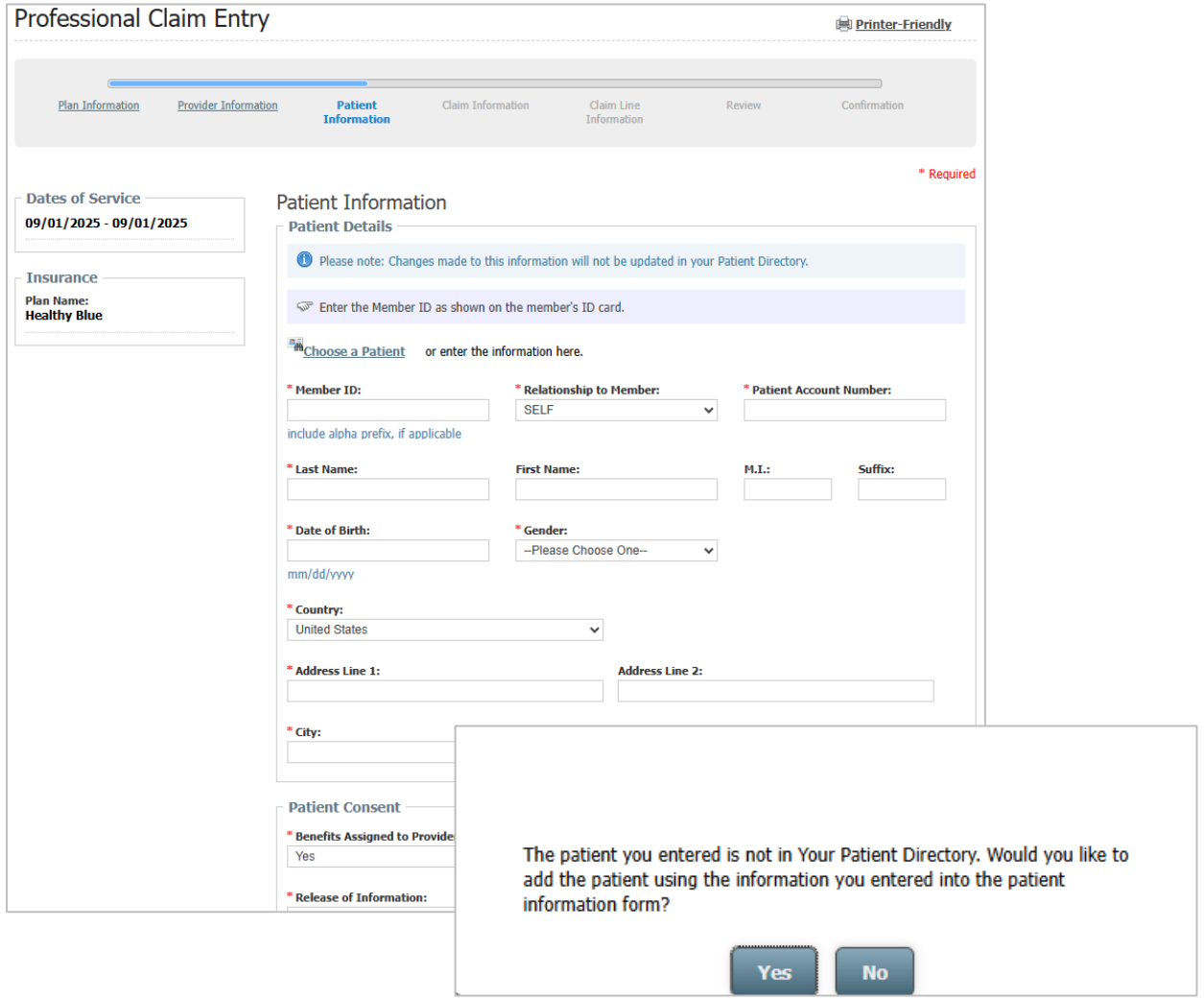
- For the provider information section, the billing location details will prepopulate based on the information associated with the TIN entered.
- Include the remaining required details.
- Select Continue.



Note: You can select Choose a Billing Provider, Choose a Rendering Provider, or Choose a Referring Provider when applicable.

Patient Information for Claim Entry

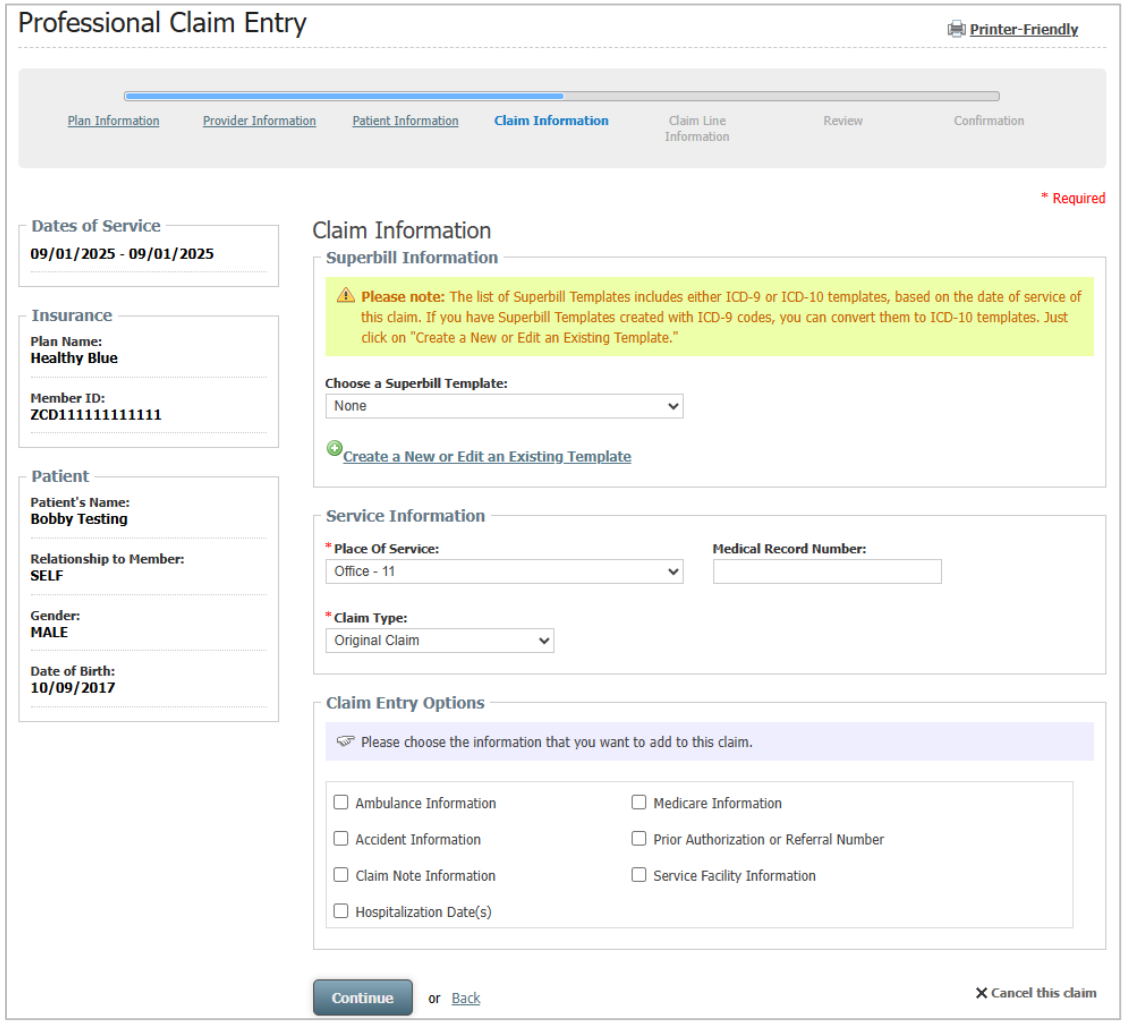
- For the patient information section, you must enter all the required details.
- Select Continue.



Claim Information for Claim Entry

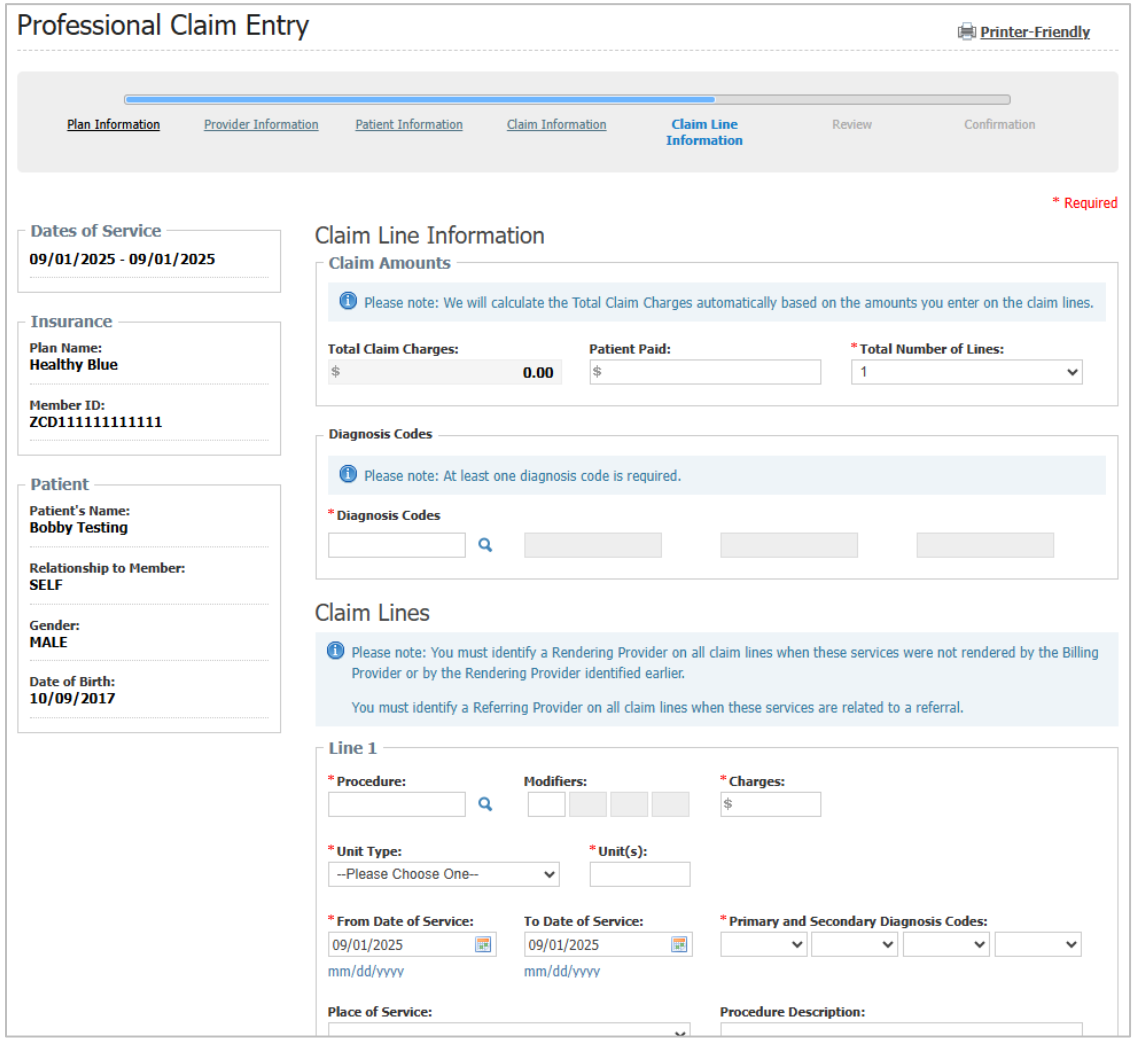
- For the claim information section, you must enter all the required details.
  - For the Claim Type, you can select one of the following:
    - Original Claim
    - Replacement Claim (Corrected Claim)
    - Void or Cancel Claim
- Select Continue.

Note: If you have a superbill template loaded, you can select it. If you would like to create one, you can choose that option.



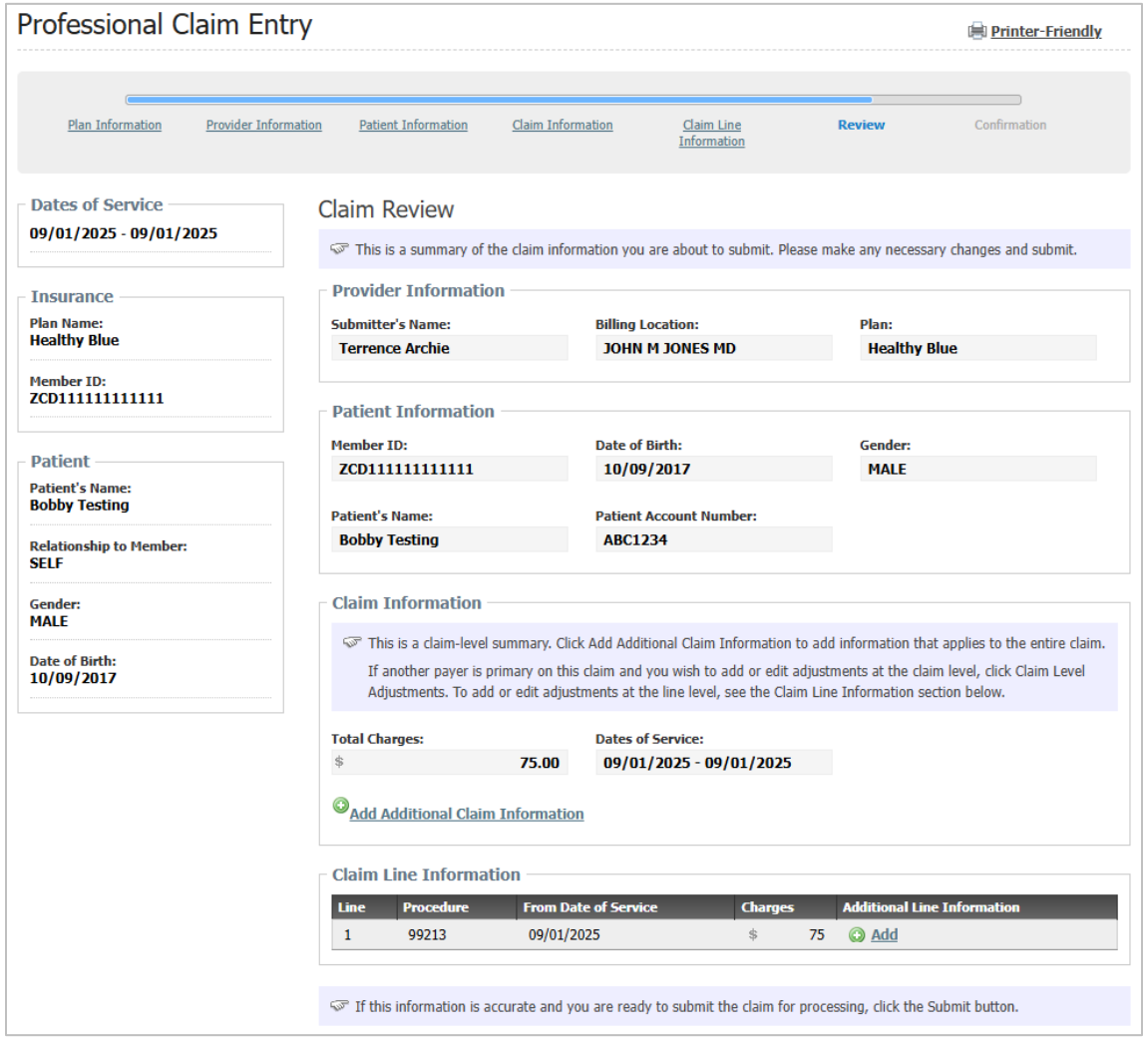
Claim Line Information for Claim Entry

- For the claim line information section, you must enter all the required details.
- Select Continue.



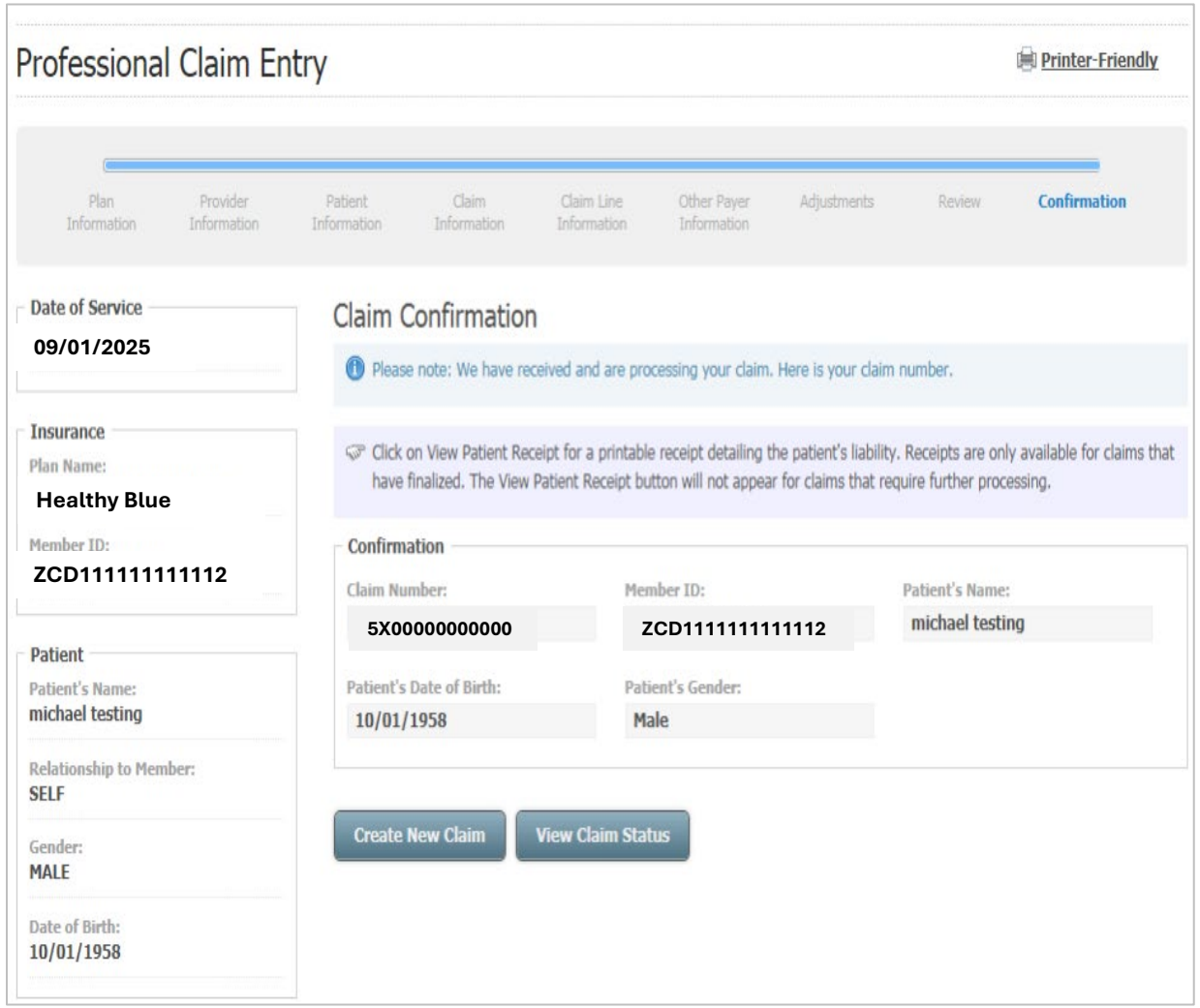
Review for Claim Entry

- For the review section, be sure to look over the details you entered.
- If corrections are needed, select Back.
- If no corrections are needed, select Submit.



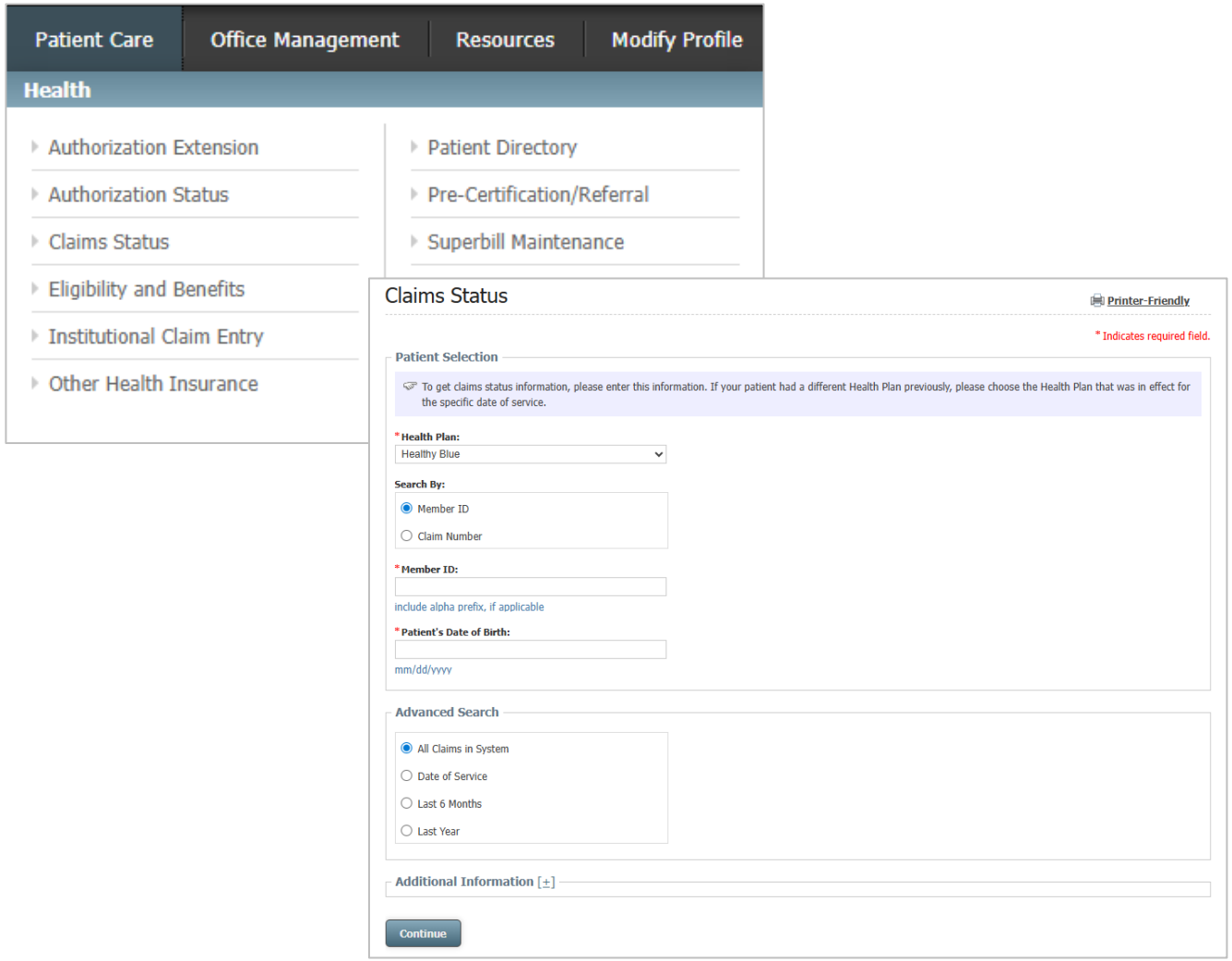
Confirmation for Claim Entry

- The confirmation page will provide you with the claim number and patient details.



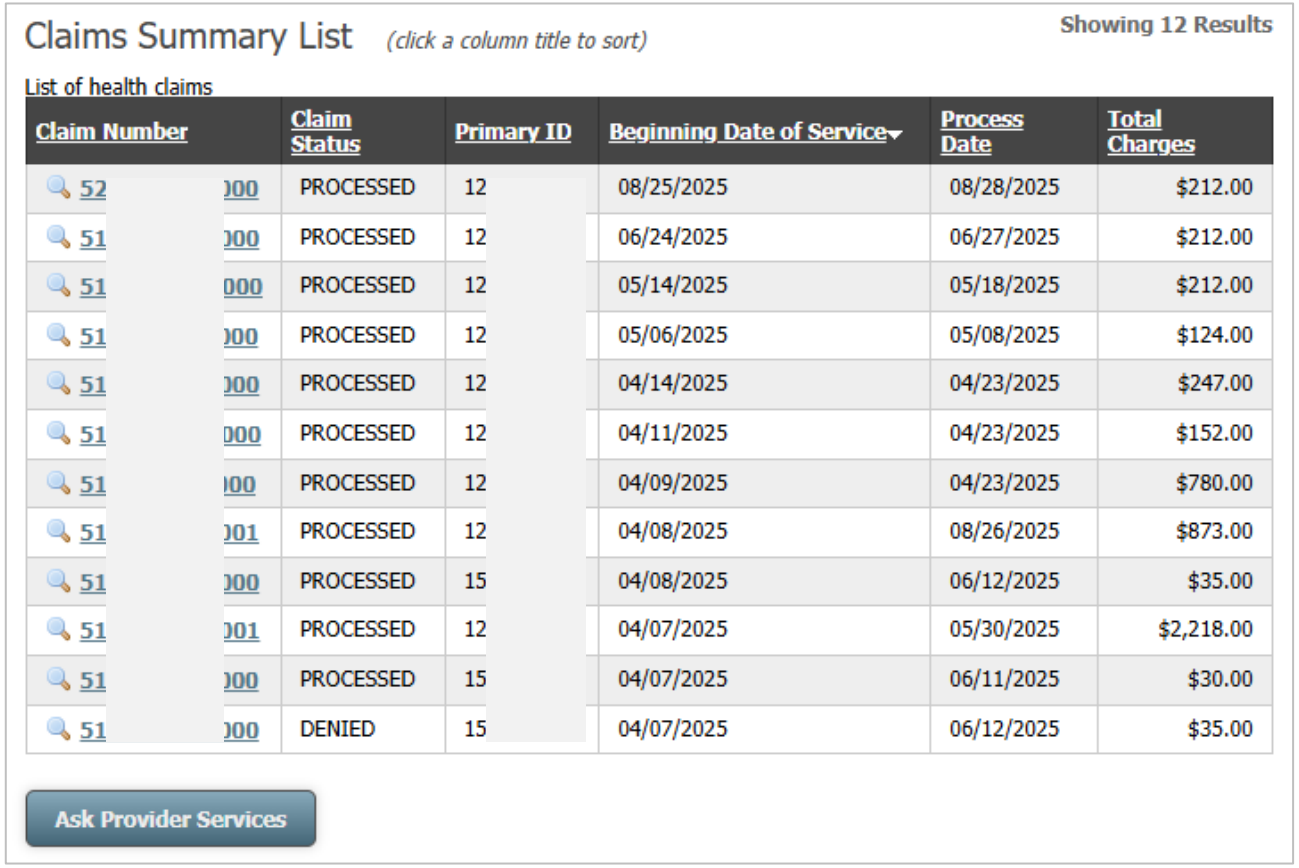
Checking Claims Status

- Under Patient Care, select Claims Status.
- Select Healthy Blue for the Health Plan.
- You can search for claims using the member's ID, which is the recommended option, or the claim number.
- When using the member's ID, you can search for all claims in the system, a specific date of service and so forth.
- Select Continue.



Claims Summary List

- The claims summary list will provide the available claims that have been processed for the patient.
  - This also includes claims that were denied.
- You will see the claim number, provider NPI, date of service, processed date and total charges.
  - Claim numbers that do not end in a zero indicate an adjustment.
- Select the appropriate claim number for more details.
- You can access Ask Provider Services from this screen as well.
  - You can submit a web inquiry or use STATchat℠ to speak with a representative.



Claims Summary List *(click a column title to sort)*

Showing 12 Results

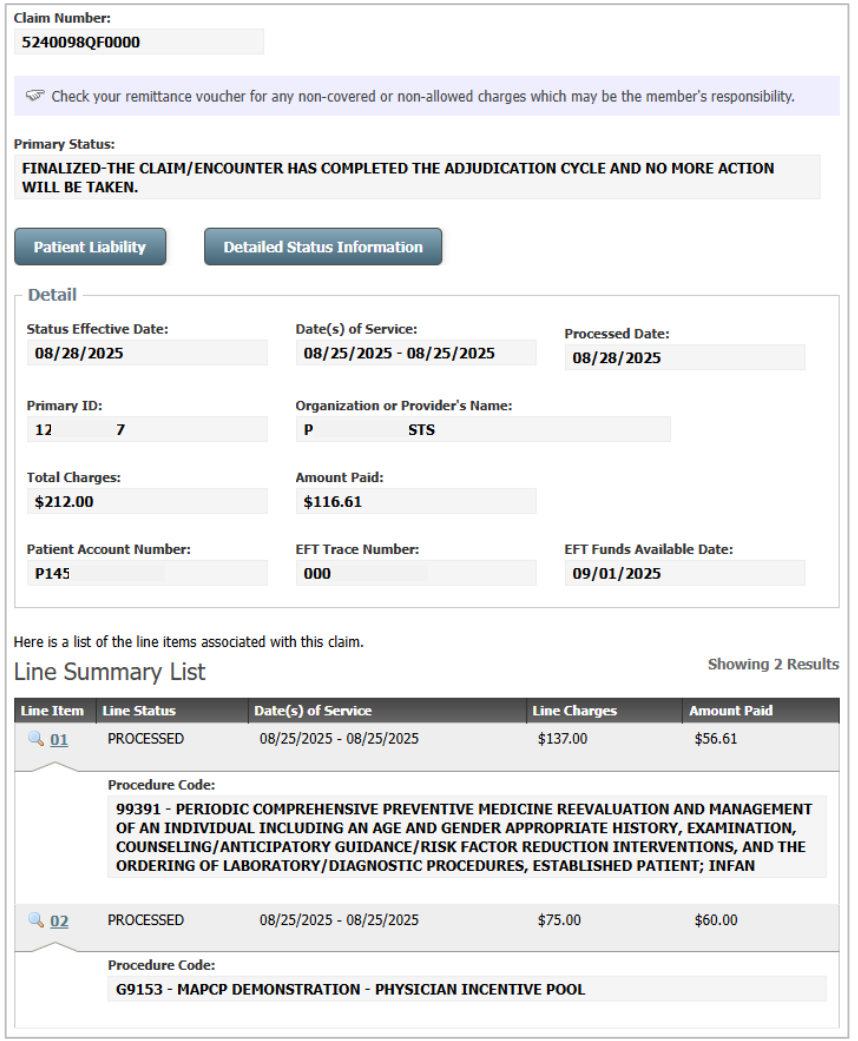
List of health claims

Claim Number	Claim Status	Primary ID	Beginning Date of Service	Process Date	Total Charges
52 000	PROCESSED	12	08/25/2025	08/28/2025	$212.00
51 000	PROCESSED	12	06/24/2025	06/27/2025	$212.00
51 000	PROCESSED	12	05/14/2025	05/18/2025	$212.00
51 000	PROCESSED	12	05/06/2025	05/08/2025	$124.00
51 000	PROCESSED	12	04/14/2025	04/23/2025	$247.00
51 000	PROCESSED	12	04/11/2025	04/23/2025	$152.00
51 000	PROCESSED	12	04/09/2025	04/23/2025	$780.00
51 001	PROCESSED	12	04/08/2025	08/26/2025	$873.00
51 000	PROCESSED	15	04/08/2025	06/12/2025	$35.00
51 001	PROCESSED	12	04/07/2025	05/30/2025	$2,218.00
51 000	PROCESSED	15	04/07/2025	06/11/2025	$30.00
51 000	DENIED	15	04/07/2025	06/12/2025	$35.00

Ask Provider Services

Claim Details

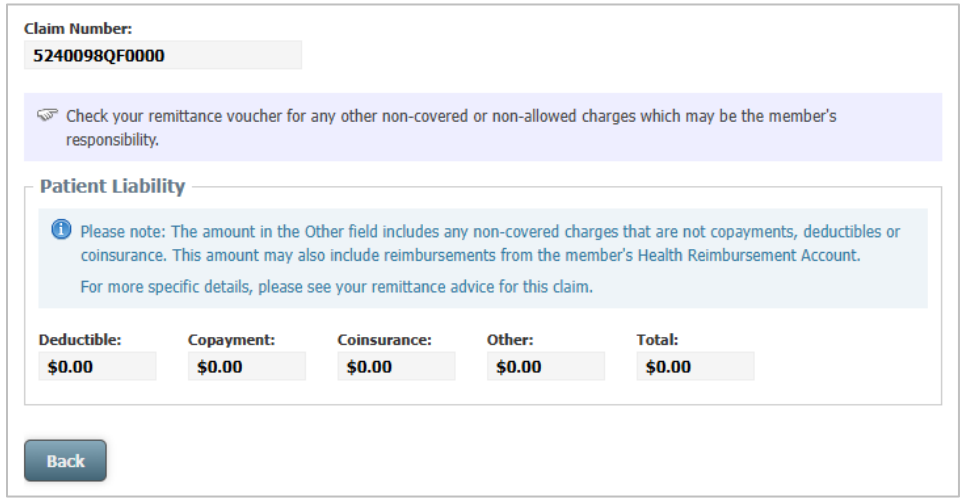
- The claims details page will provide lots of information to include:
  - Patient liability
  - Detailed status information
  - Provider details
  - Patient account number
  - EFT details
  - Line summary

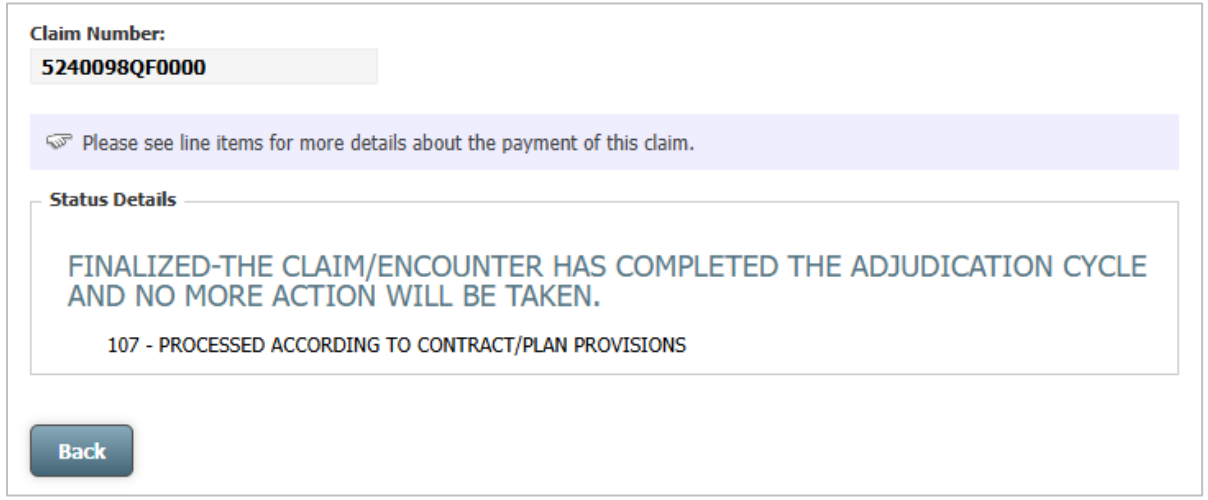


Note: You can select Patient Liability or Detailed Status Information for additional details on the claim.

Patient Liability and Detailed Status Information

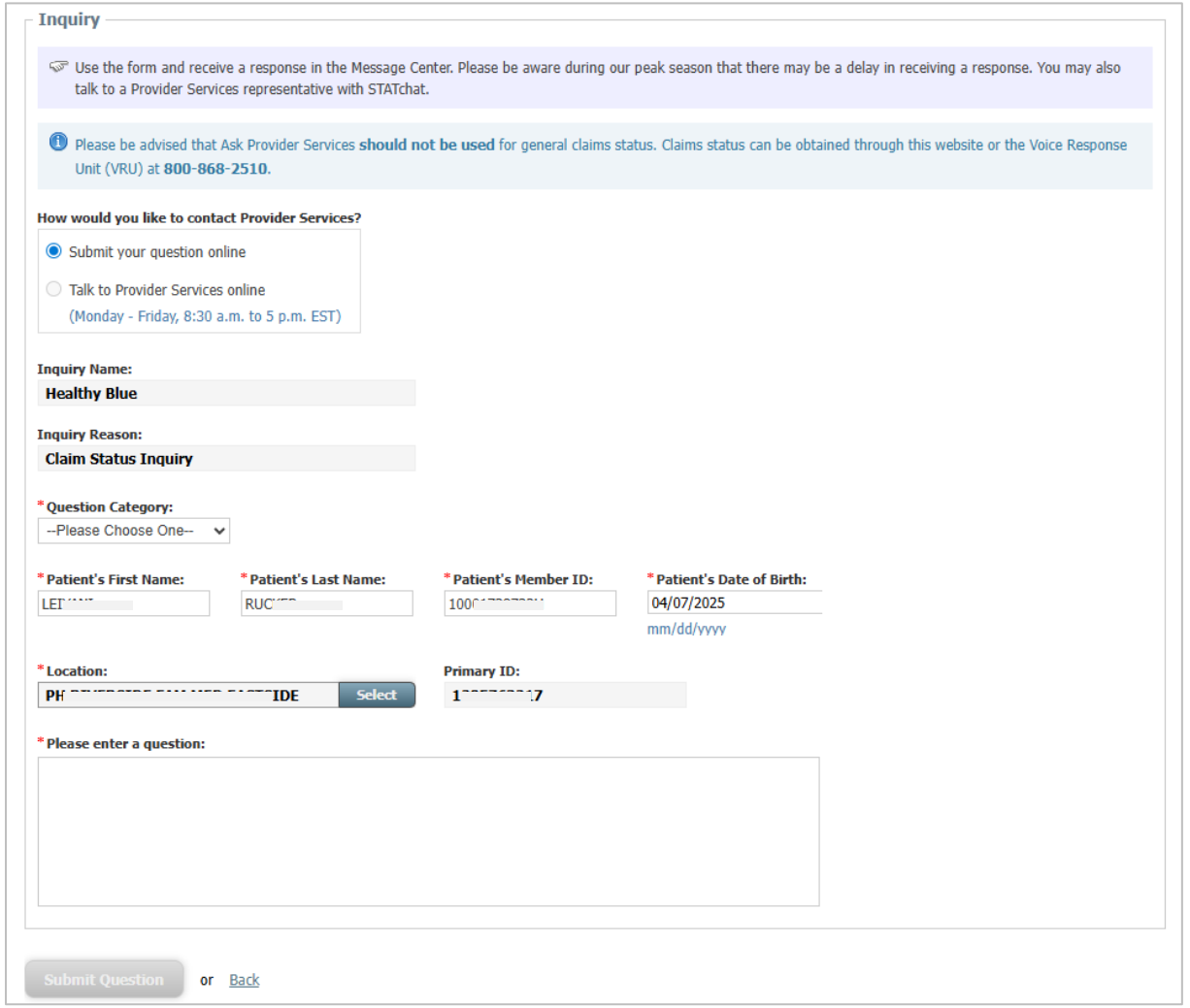
- The patient liability option will show any applicable patient responsibility.
- The detailed status information option will show more processing details.





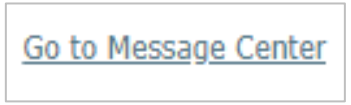
Submitting Web Inquiries

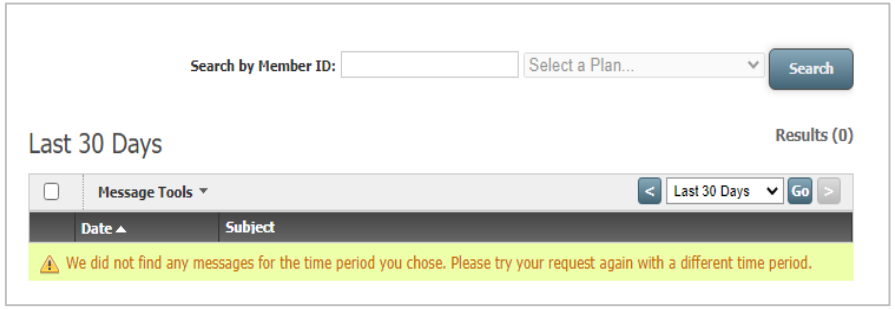
- Ask Provider Services is a feature in My Insurance Manager that lets you submit secured web inquiries for help with claims.
- This feature is intended to assist with complex issues and not general claim status.
- Examples of appropriate questions to ask:
  - Why was line one of the claim denied as noncovered?
  - Has the member returned the coordination of benefits questionnaire?
- Examples of inappropriate questions to ask:
  - What is the status of the claim?
  - Has the claim been processed?

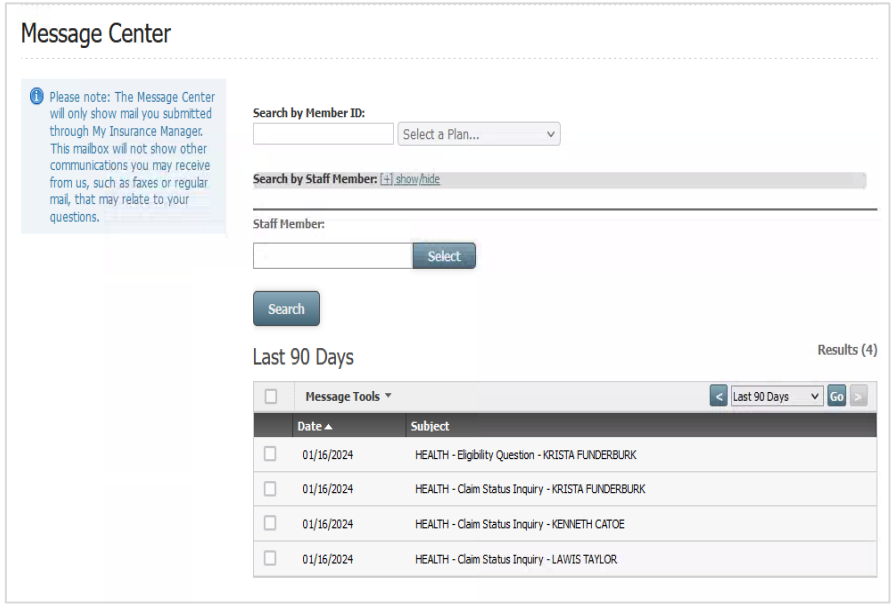


Reviewing Web Inquiries

- To view responses to your inquiries:
  - Select Go to Message Center.
  - You can narrow the results by entering the ID number and selecting specific months.
- Enhancements made:
  - You now have the option to see up to 90 days of inquiries.
  - Provider administrators can view all the web inquiries submitted and responses received under the TIN.
    - Enter the member's ID number and select the staff member from the drop-down menu.

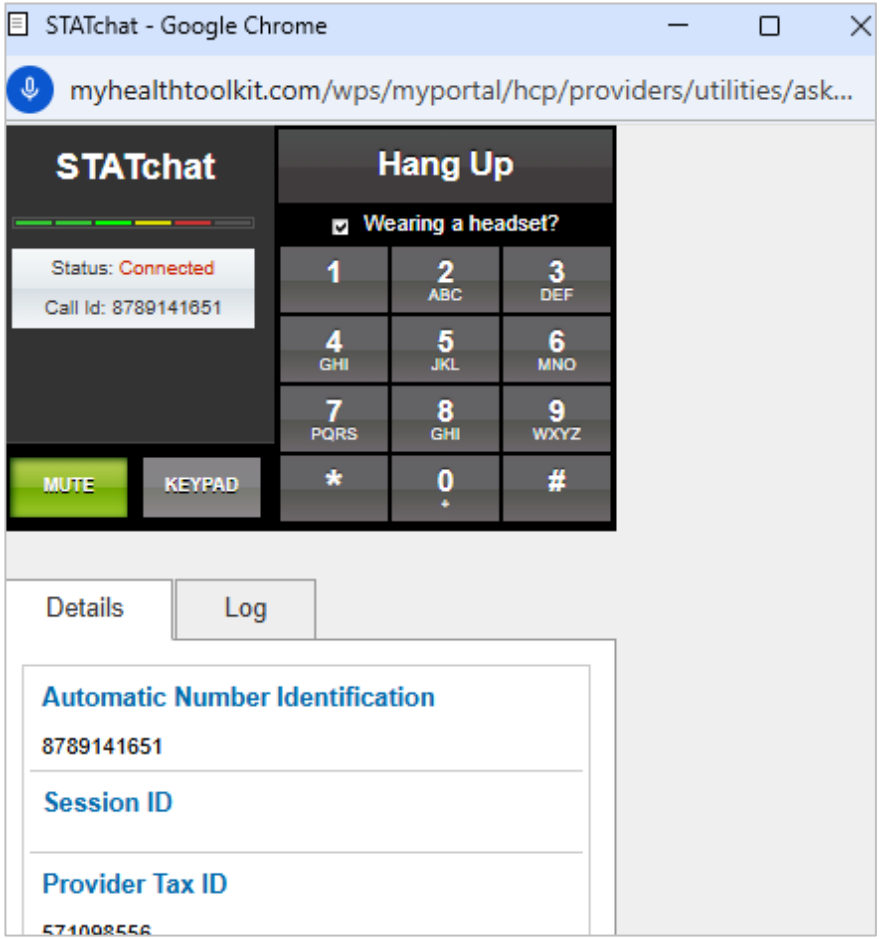






Using STATchat

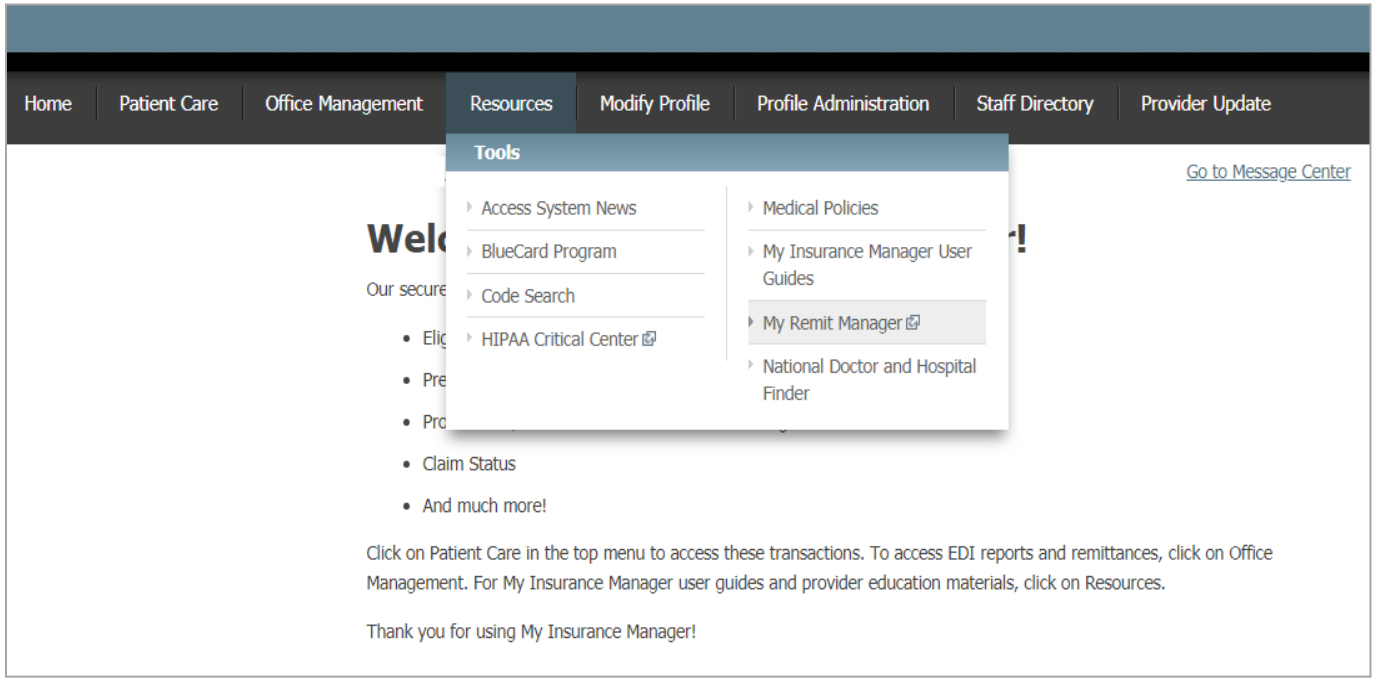
- STATchat is a fast and simple way to speak with a Provider Services representative.
- The feature is available through My Insurance Manager.
- System requirements include:
  - A current version of Adobe Flash Player
  - A compatible web browser, such as Microsoft Edge or Google Chrome.
  - A headset or standalone microphone with speakers connected to your computer.



My Remit Manager

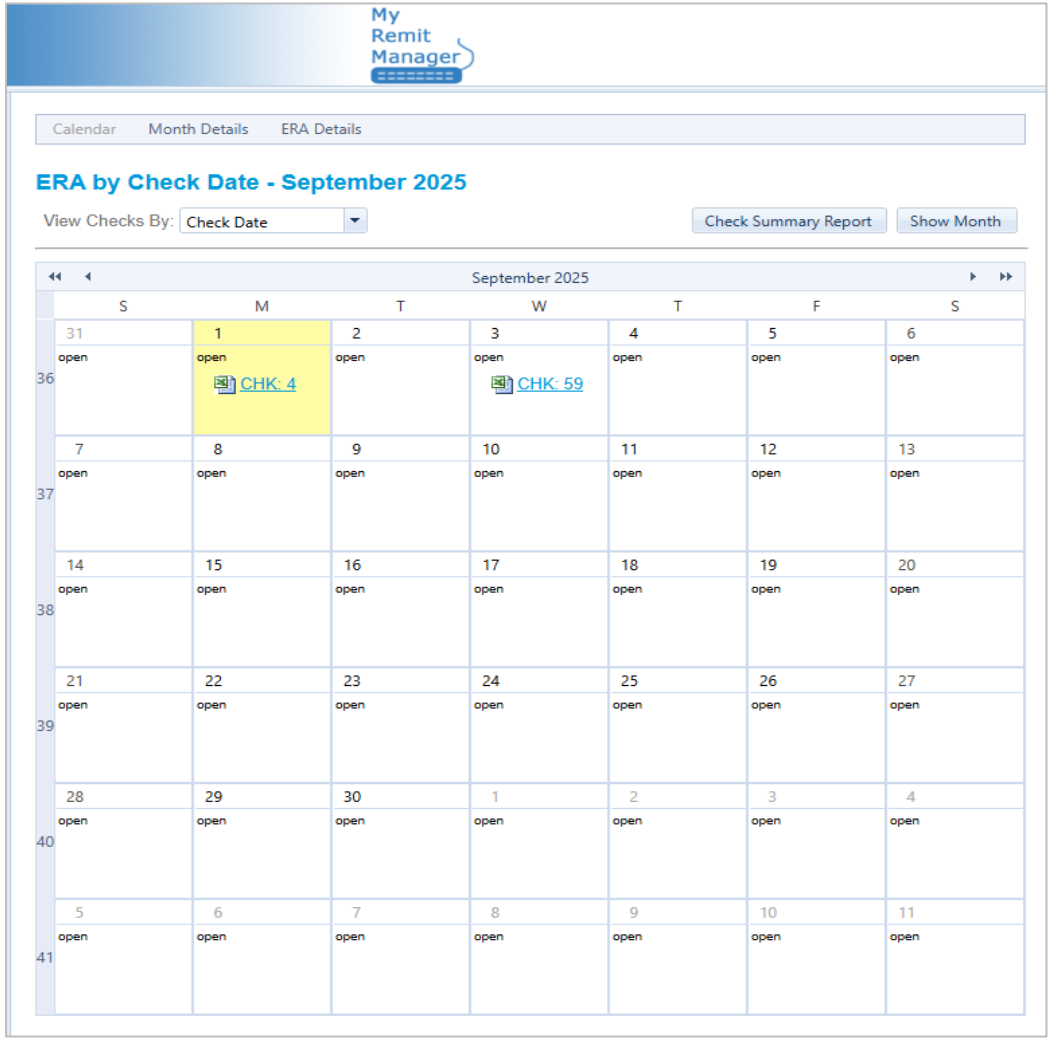
Accessing My Remit Manager

- While in My Insurance Manager, hover over Resources and select My Remit Manager.



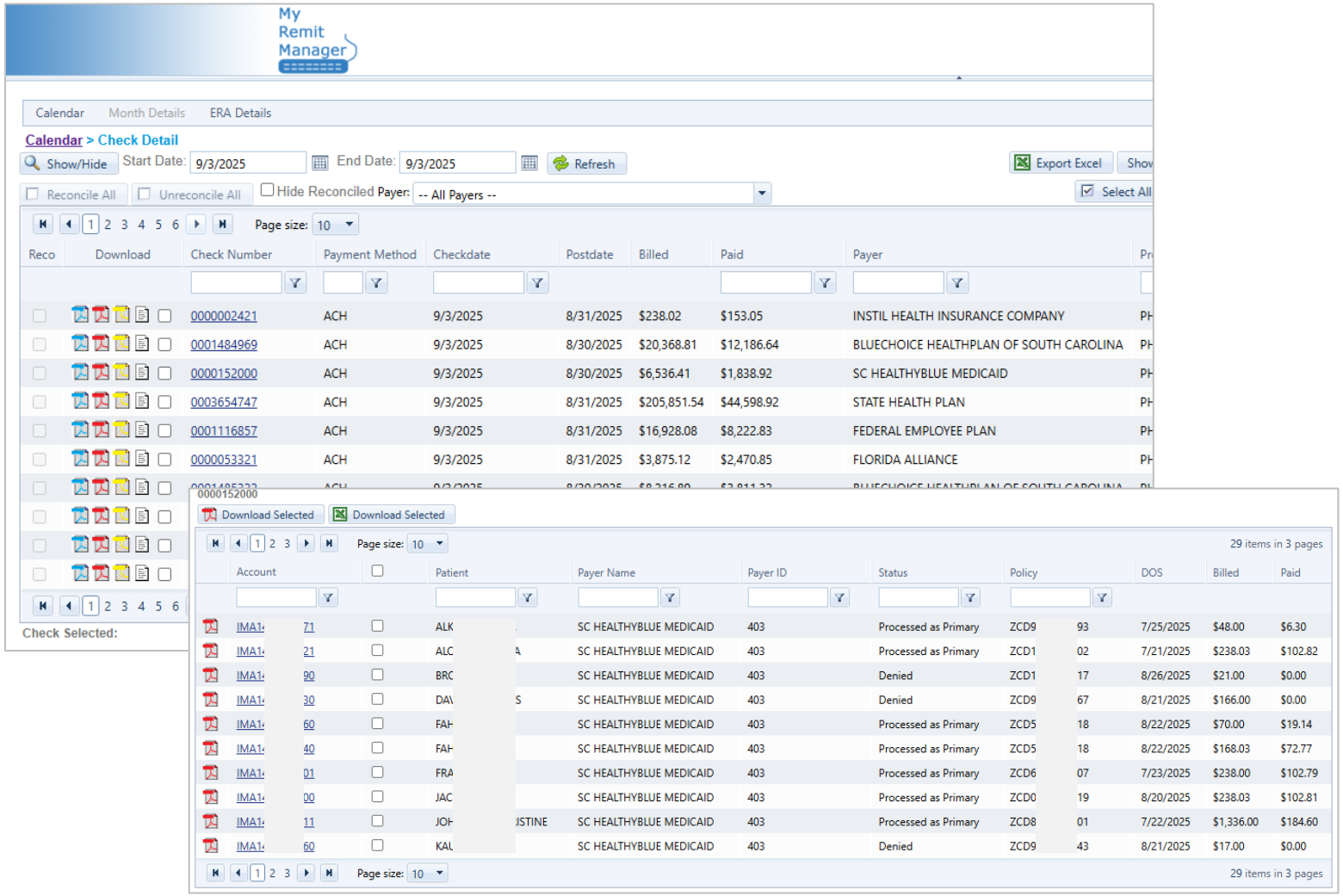
Available Remittances – Calendar View

- If remittances are available, there will be check links on the calendar.
- You can view previous months by selecting the appropriate arrows on the calendar.



Viewing Available Remittances

- You can view remittances based on the check number, payment amount, or payer.
- If you select a specific check number, the applicable remittances will populate.
- From the available remittances under the selected check number, select the Adobe PDF icon.



Example of Remittance

ERA Patient Listing

Electronic Reproduction ASC 005010X221A1

PH UNI AL GRP

A 74

AL FA **CHECK/EFT: 00 00** **CHECK DATE: 09/03/2025**

SC HEALTHYBLUE MEDICAID

Account: IMA1445923771 POS: 11 HIC: ZCD97 3 ICN: 5240097MD0000 Provider: 108 5 571004 3295641

Status: Processed as Primary

PreProv	ServDate	NOS	REV	Proc/Mods	Billed	Allowed	Deduct	Coins	RC-Amt	Paid	CAS Summary
571004971	07/25/2025	1		HC:36415	17.00				17.00	0.00	CO 45 17.00 HE N174
571004971	07/25/2025	1		HC:85025:QW	31.00	6.30			24.70	6.30	CO 45 24.70 HE N45
REMITTANCE SUMMARY					48.00	6.30	.00	.00	41.70	6.30	

TOTALS

Denied/Non-Covered: 0.00

CO	45	41.70	[Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).]
HE	N45		[Payment based on authorized amount.]
HE	N174		[This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group "PR".]

* Denotes Denied Or Non-covered Charges

REMITTANCE SUMMARY

	Billed	Allowed	Deduct	Coins	RC-Amt	PLB Adj	Paid
Totals	48.00	6.30	.00	.00	41.70	.00	6.30

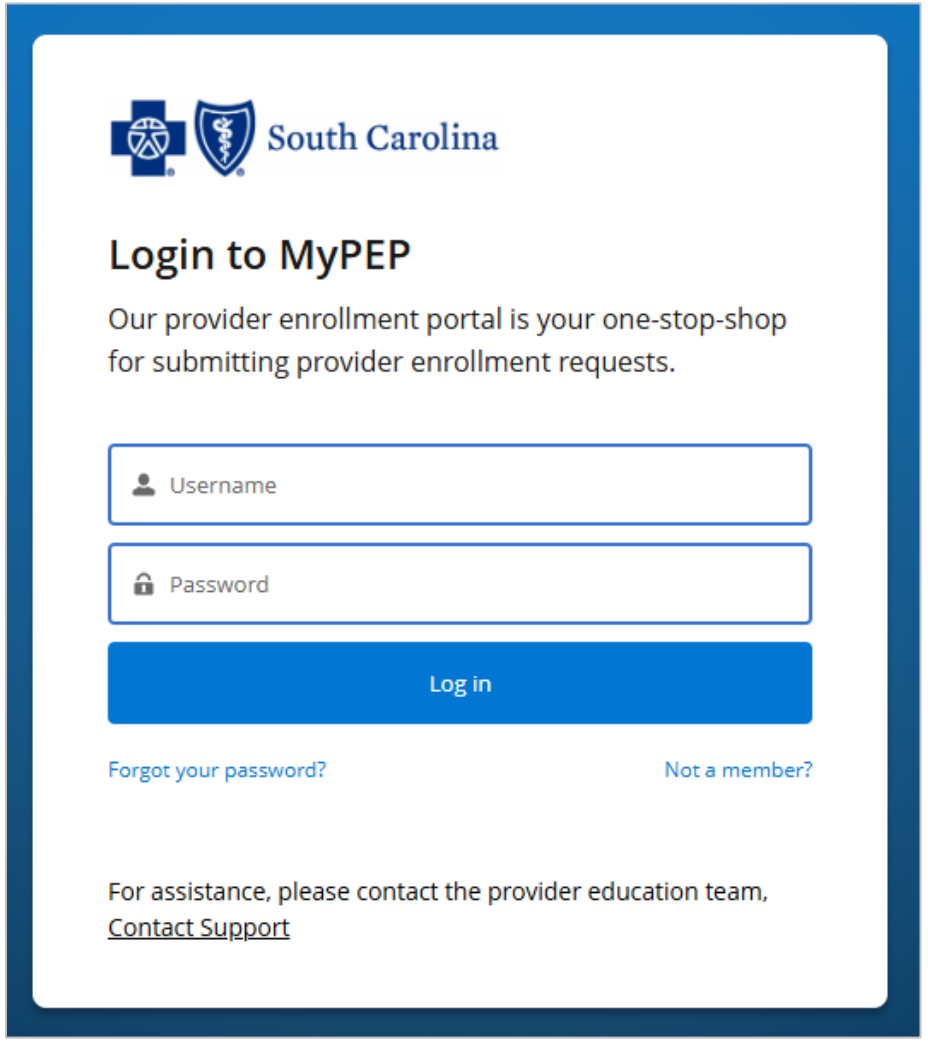
My Provider Enrollment Portal

Joining the Healthy Blue Network

- When it comes to the credentialing process for the Healthy Blue network, providers have the right to:
  - Review information obtained from outside sources (i.e., state licensing boards) used to evaluate their credentialing application.
    - This does not include references, recommendations, or other peer-review protected information.
  - Correct any erroneous information submitted by outside sources.
    - If the credentialing staff identifies a discrepancy, they will notify the provider in writing (case comment).
  - Question the status of their credentialing application and receive a response by phone or email within seven calendar days to include:
    - The date their completed application was received.
    - Any outstanding items needed for completion.
    - The expected date of the credentialing decision.
- To exercise the above rights, please fax your inquiries to 803-870-9997.
  - Inquiries can be submitted using a free formed letter.

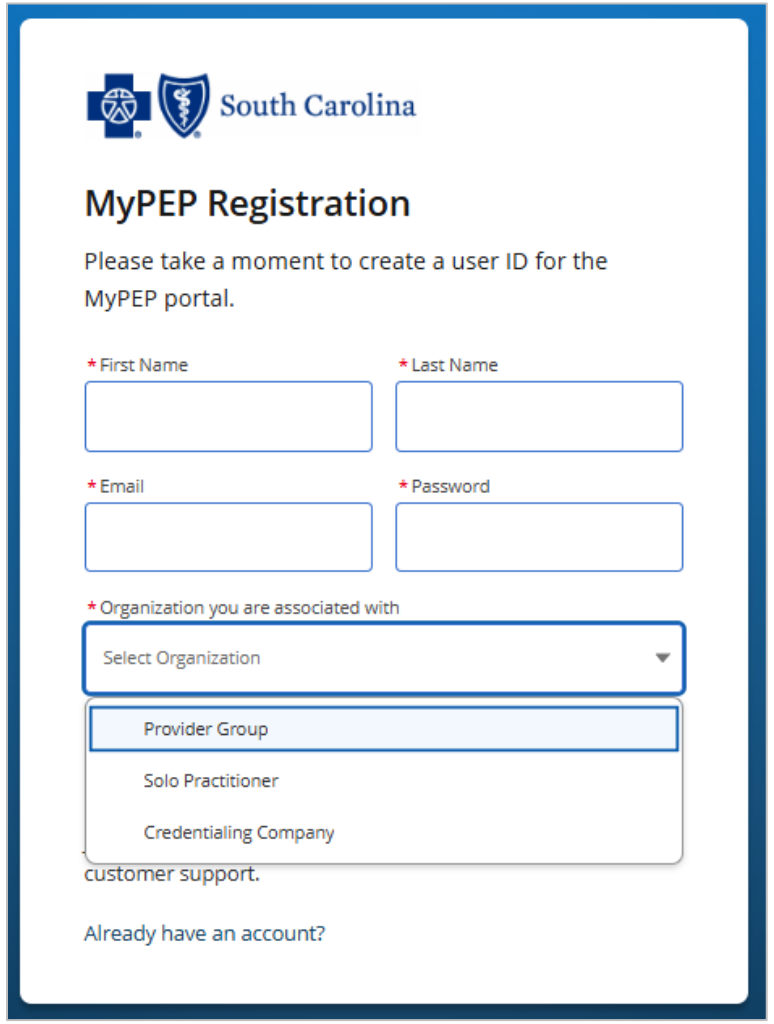
Registering for My Provider Enrollment Portal

- From the Provider section of the Healthy Blue website, select Join Our Networks.
- New users should select Not a member from the landing page of the portal.



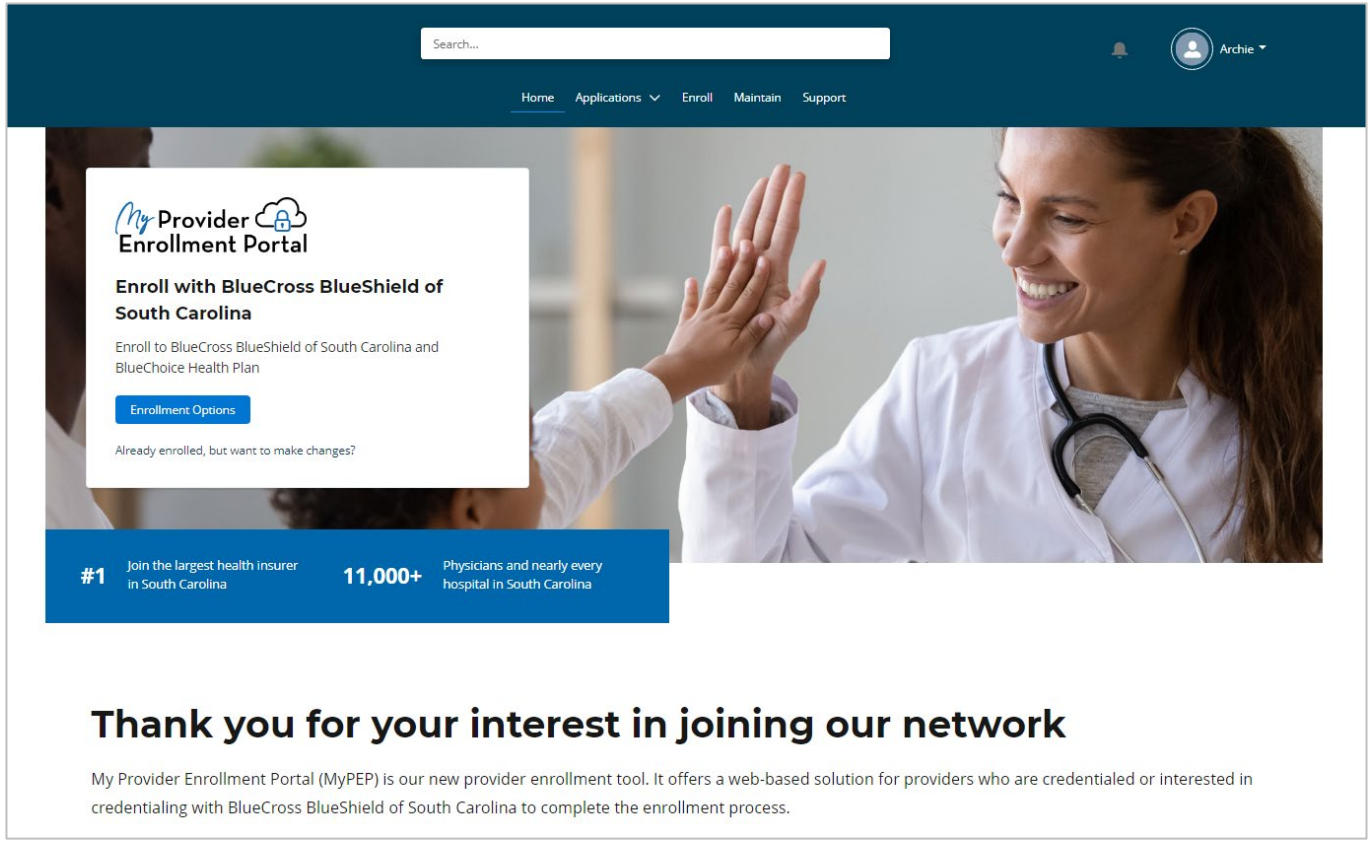
Registration Options

- Registration options include:
  - Solo practitioner
  - provider group
  - Credentialing company



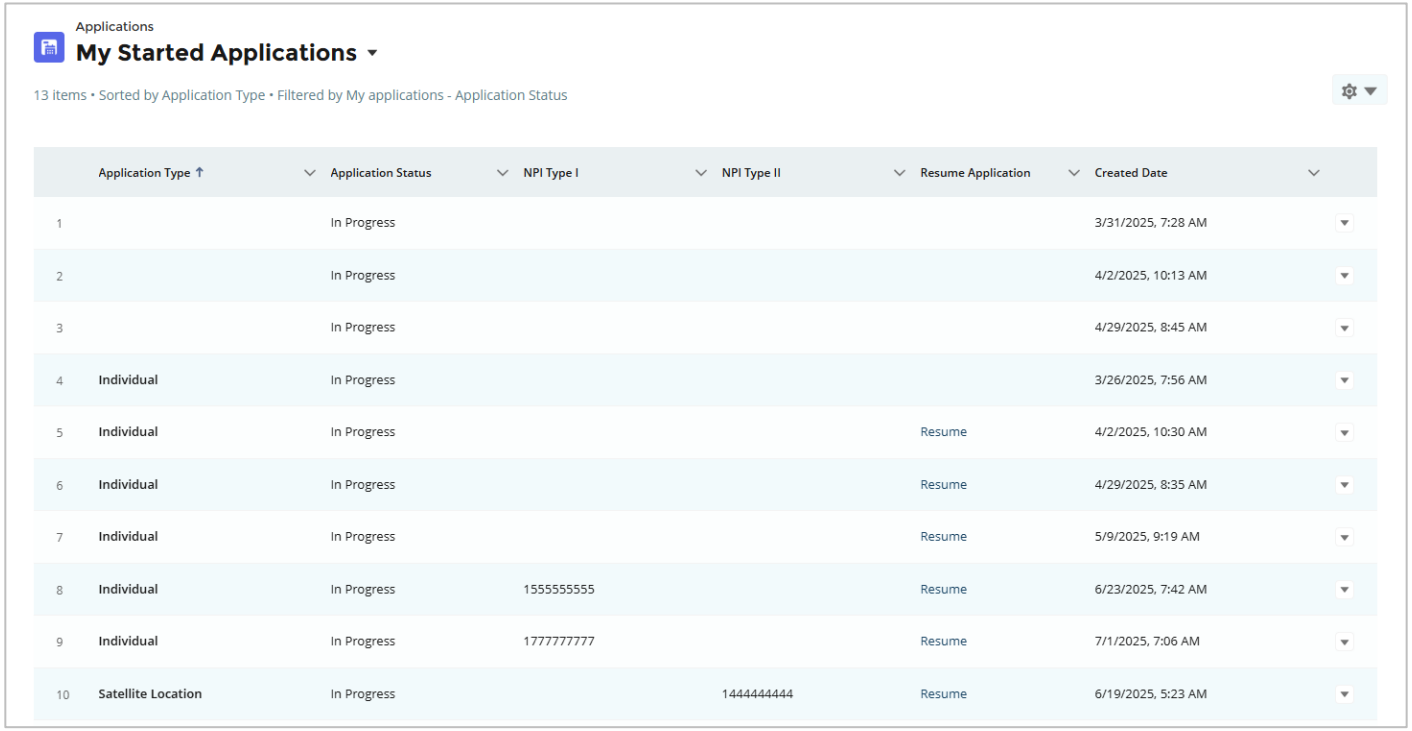
Home Page of My Provider Enrollment Portal

- From the home page, you will see the following options in the navigation bar:
  - Home
  - Applications
    - My Started Applications
    - My In Progress Applications
    - My Applications Action Required
    - My Closed Applications
  - Enroll
  - Maintain
  - Support



My Started Applications

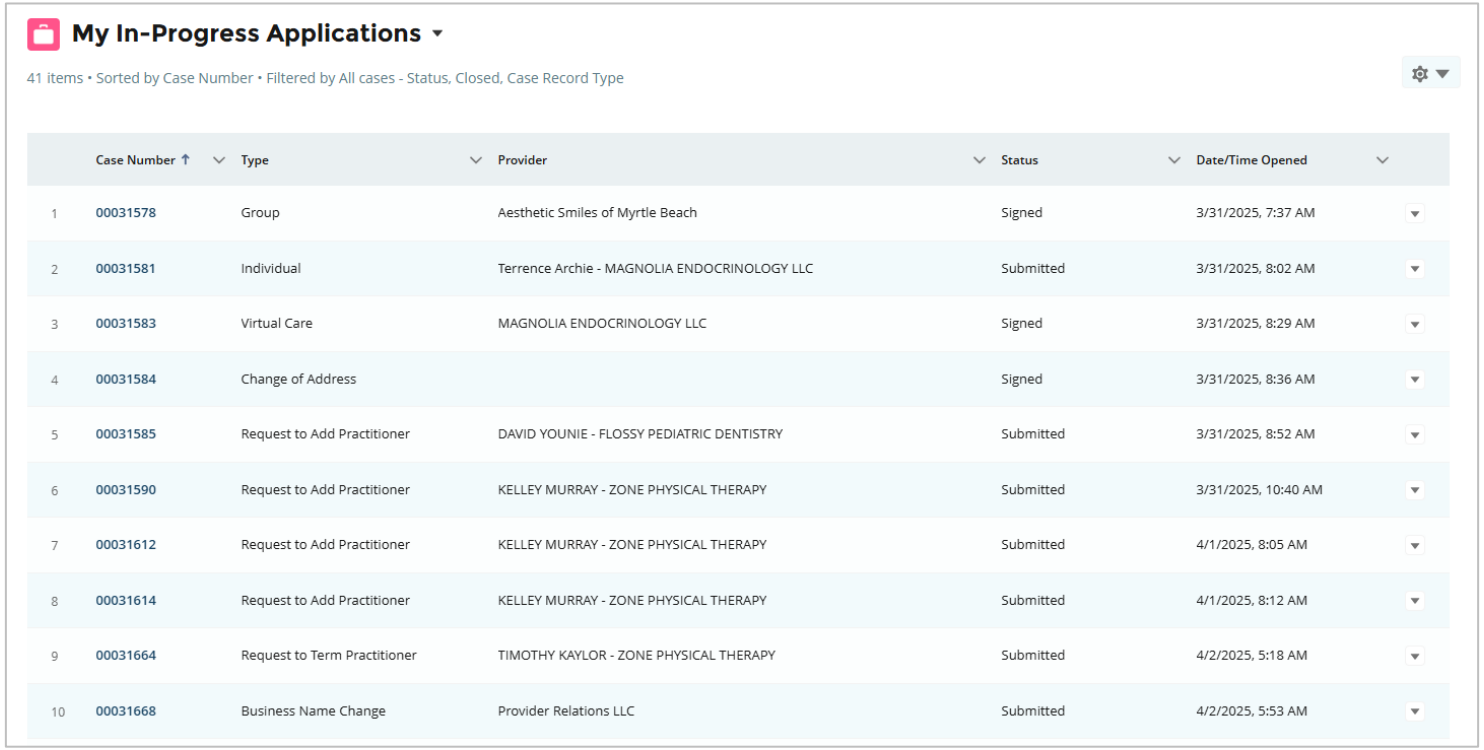
- Under My Started Applications, you will see all the applications you have started but not submitted in the portal.



	Application Type	Application Status	NPI Type I	NPI Type II	Resume Application	Created Date
1		In Progress				3/31/2025, 7:28 AM
2		In Progress				4/2/2025, 10:13 AM
3		In Progress				4/29/2025, 8:45 AM
4	Individual	In Progress				3/26/2025, 7:56 AM
5	Individual	In Progress			Resume	4/2/2025, 10:30 AM
6	Individual	In Progress			Resume	4/29/2025, 8:35 AM
7	Individual	In Progress			Resume	5/9/2025, 9:19 AM
8	Individual	In Progress	1555555555		Resume	6/23/2025, 7:42 AM
9	Individual	In Progress	1777777777		Resume	7/1/2025, 7:06 AM
10	Satellite Location	In Progress		1444444444	Resume	6/19/2025, 5:23 AM

My In Progress Applications

- Under My In-Progress Applications, you will see a list of applications that you have submitted.
- You are provided the case number, type of application, provider details and status of the case.



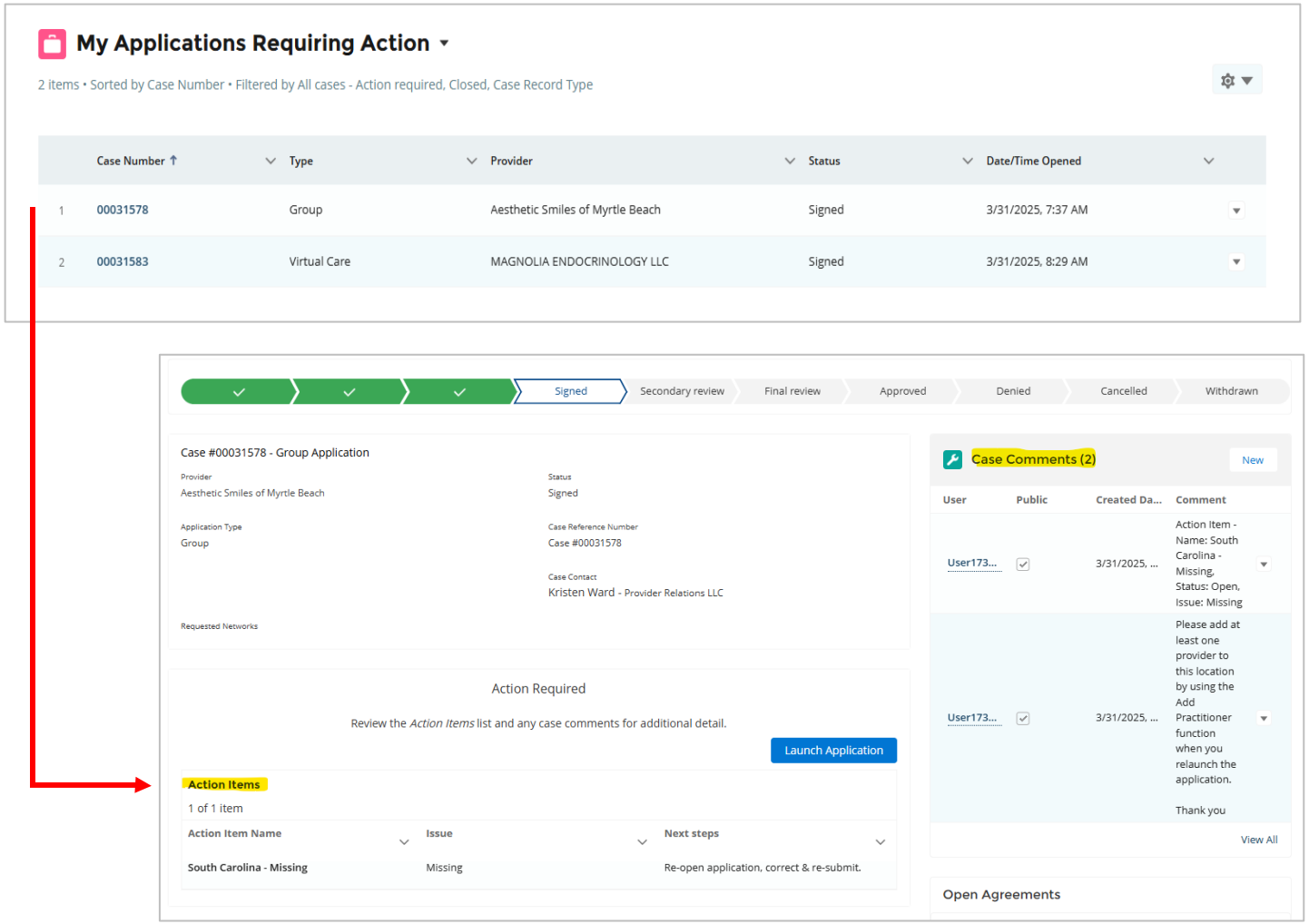
My In-Progress Applications

41 items • Sorted by Case Number • Filtered by All cases - Status, Closed, Case Record Type

	Case Number ↑	Type	Provider	Status	Date/Time Opened
1	00031578	Group	Aesthetic Smiles of Myrtle Beach	Signed	3/31/2025, 7:37 AM
2	00031581	Individual	Terrence Archie - MAGNOLIA ENDOCRINOLOGY LLC	Submitted	3/31/2025, 8:02 AM
3	00031583	Virtual Care	MAGNOLIA ENDOCRINOLOGY LLC	Signed	3/31/2025, 8:29 AM
4	00031584	Change of Address		Signed	3/31/2025, 8:36 AM
5	00031585	Request to Add Practitioner	DAVID YOUNIE - FLOSSY PEDIATRIC DENTISTRY	Submitted	3/31/2025, 8:52 AM
6	00031590	Request to Add Practitioner	KELLEY MURRAY - ZONE PHYSICAL THERAPY	Submitted	3/31/2025, 10:40 AM
7	00031612	Request to Add Practitioner	KELLEY MURRAY - ZONE PHYSICAL THERAPY	Submitted	4/1/2025, 8:05 AM
8	00031614	Request to Add Practitioner	KELLEY MURRAY - ZONE PHYSICAL THERAPY	Submitted	4/1/2025, 8:12 AM
9	00031664	Request to Term Practitioner	TIMOTHY KAYLOR - ZONE PHYSICAL THERAPY	Submitted	4/2/2025, 5:18 AM
10	00031668	Business Name Change	Provider Relations LLC	Submitted	4/2/2025, 5:53 AM

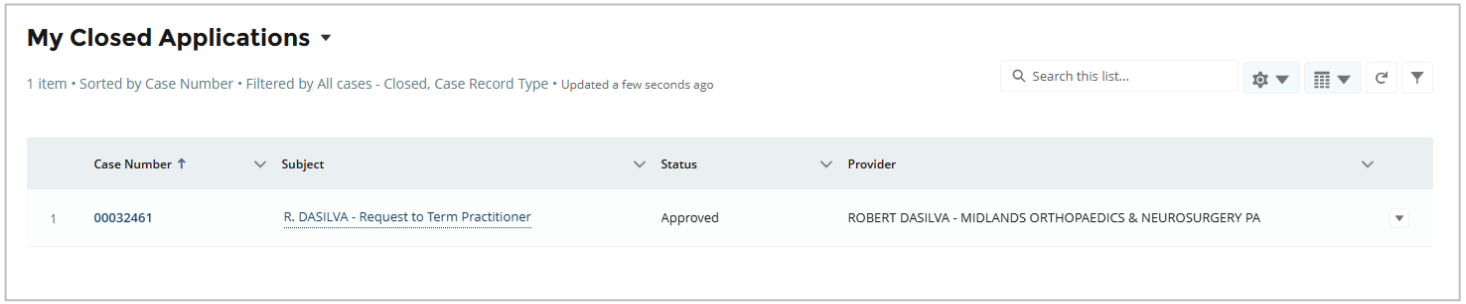
My Applications Action Required

- Under My Applications Requiring Action, you will be provided a list of cases that need attention.
- Select the case number.
- Review the action items.
- Once you are ready to make corrections, select Launch Application.



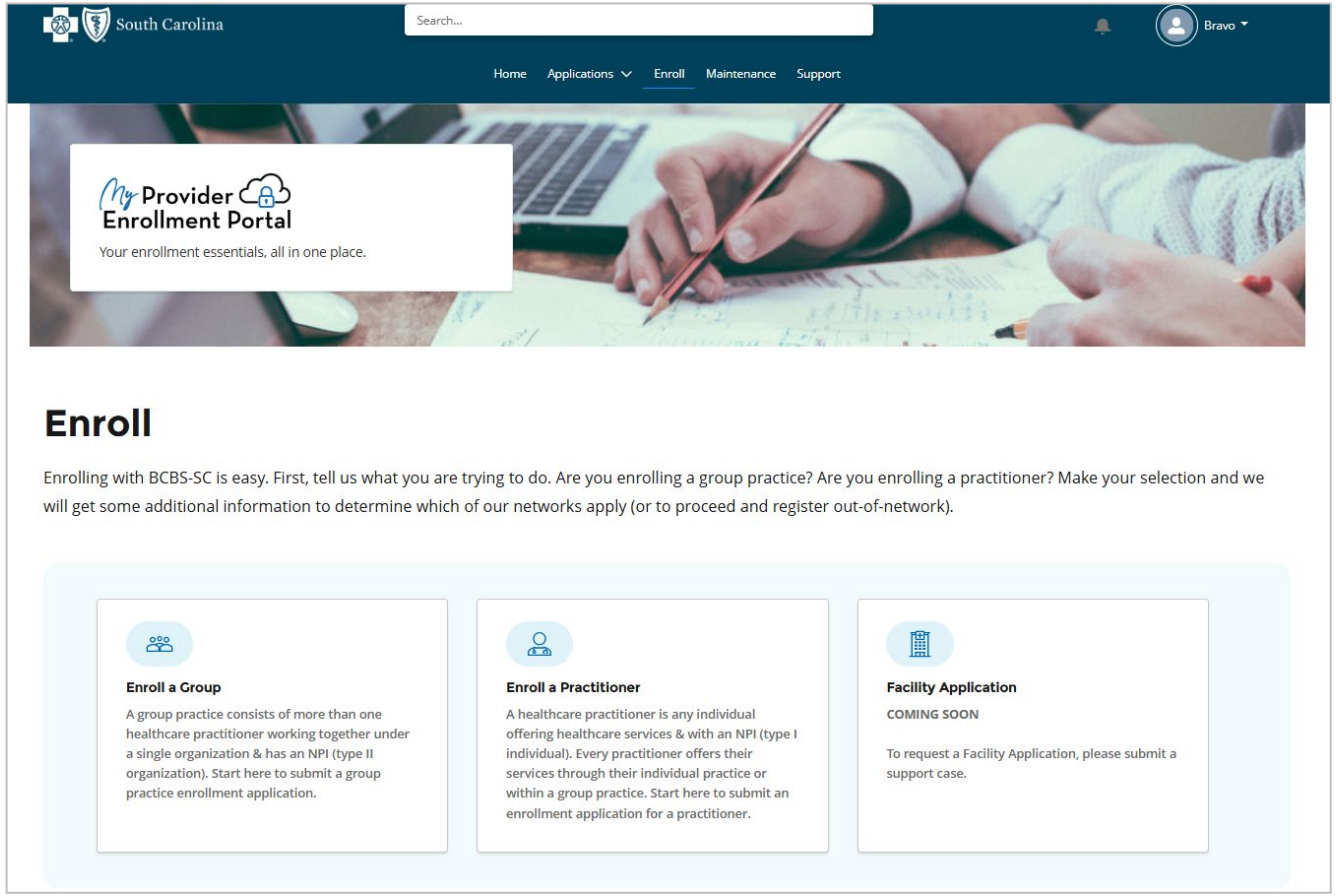
My Closed Applications

- Under My Closed Applications, you will be provided a list of applications that have been completed and closed.
- Applications listed here can be:
  - Approved.
  - Denied.
  - Canceled.
  - Withdrawn.



Enroll Page of My Provider Enrollment Portal

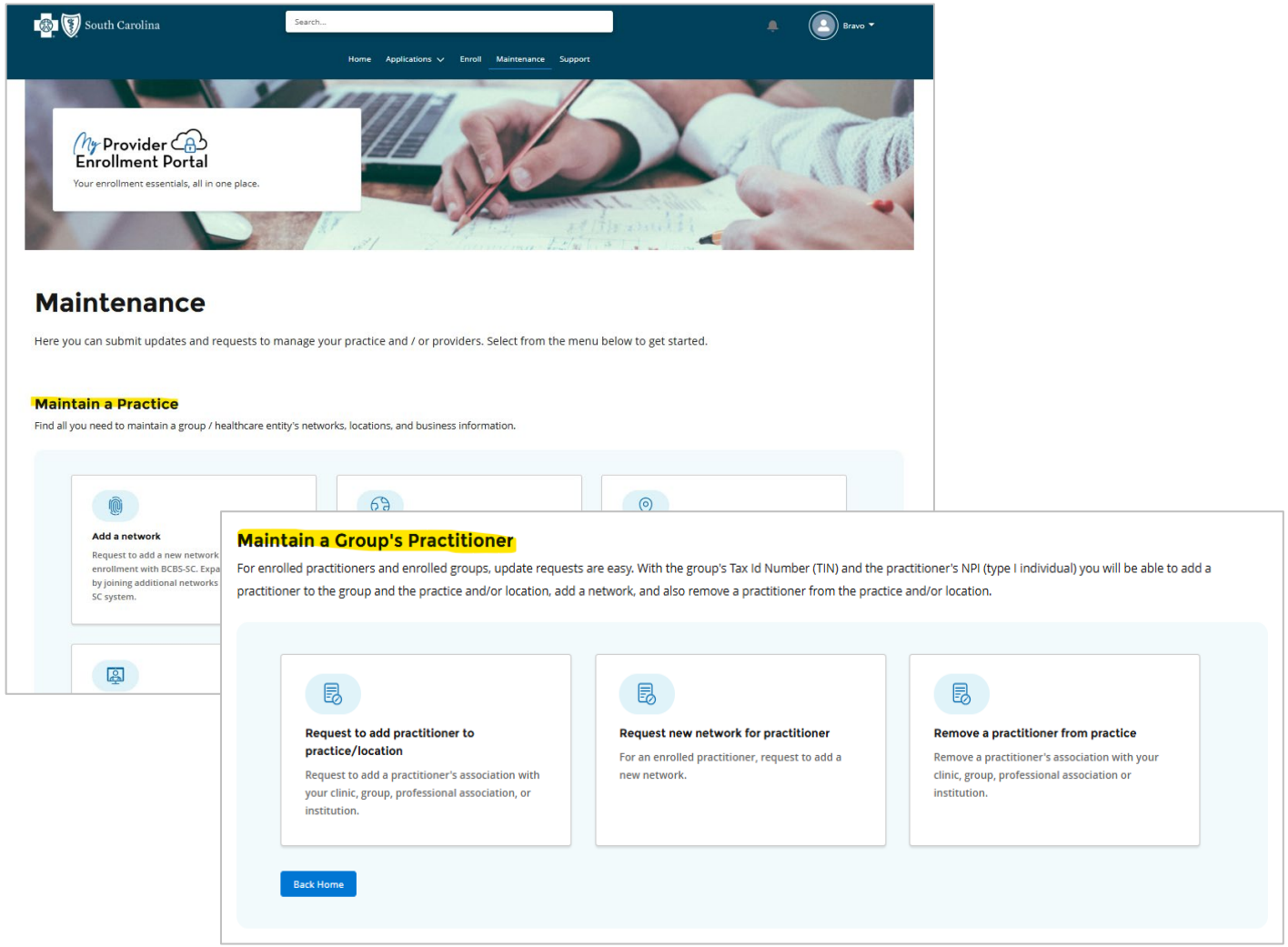
- On the Enroll page, you will have the option to enroll a group or practitioner.
- Facility applications are forthcoming.



Note: You must have Medicaid ID number for the group or practitioner to enroll in the Healthy Blue network.

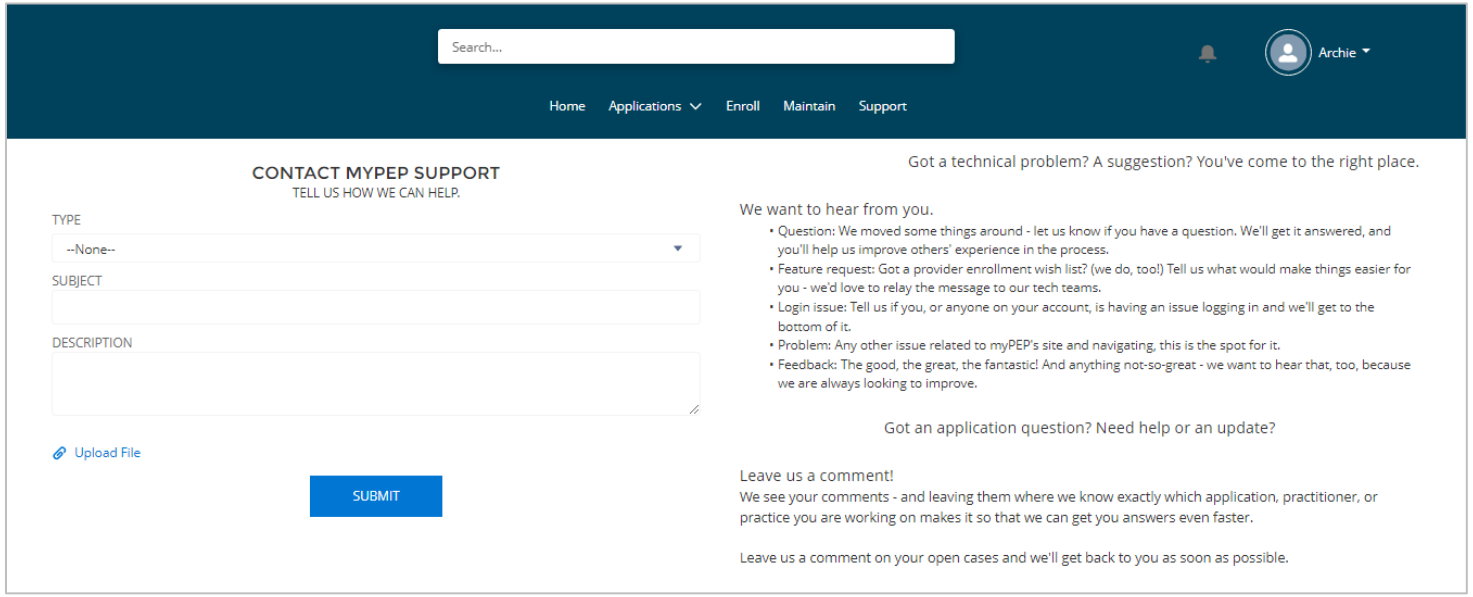
Maintenance Page of My Provider Enrollment Portal

- On the Maintenance page, you will have options for the practice and the practitioner.
- For the practice, you can:
  - Add a network
  - Add a satellite location
  - Add virtual care
  - Change an address
  - Change the name
  - Submit an NPI Provider Notification
    - Only for out-of-state and out-of-network providers.
- For the practitioner, you can:
  - Add a practitioner to a practice location
  - Remove a practitioner from a practice location
  - Request a new network



Support Page of My Provider Enrollment Portal

- On the Support page, you will have the option to submit a question to the enrollment team.
- Available inquiry types include:
  - Login issues
  - Feature request
  - General question
  - Problem
  - Feedback
  - Access request



Statuses in My Provider Enrollment Portal

- **Submitted** – The application and all required documents have been sent to BlueCross BlueShield of South Carolina for review. Note: Submitted does not mean completed.
- **Preliminary Review** – The application is in the first review stage to ensure it's clean.
- **Awaiting Signature** – The application and applicable contracts have been sent to the provider (and other designated signers) for signatures.
- **Signed** – The application and applicable contracts have been signed.
- **Secondary Review** – The application has progressed to the next review stage.
- **Final Review** – The application has reached the final review stage.
- **Approved** – The application has been approved.
- **Denied** – The application has been denied.
- **Cancelled** – The application has been cancelled.
- **Withdrawn** – The application has been withdrawn per the provider's request.

Steps to Submitting Clean Applications

1. Complete the enrollment application inside the portal.
2. Sign the application and contracts electronically.
   - The documents that must be signed will be sent to the appropriate parties included on the application.
     - It is important to include the correct email addresses for each individual (i.e., provider, fiduciary contact, etc.)
   - These items will be available once the enrollment team sends the documents to you, and the case is in the awaiting signature status.
3. If additional items are requested, submit those as soon as possible.

Note: Review the available manual and videos online for details on specific application types.

Overview of Member Benefits

Member Identification Cards

- Members should present both their Healthy Blue and Healthy Connections ID cards at each visit.
- Use the Healthy Blue ID card to verify the member's eligibility and benefits in My Insurance Manager.

Fee Schedules and Manuals

- Fee Schedules
  - Listed by provider specialty type
  - Codes (including modifiers) listed on fee schedules are considered for reimbursement
  - Medicaid Managed Care Organization plans must offer the same benefits as Healthy Connections
- Manuals
  - Listed by service type
  - Includes general information, billing details, claims filing guidelines and more

Note: *Visit www.scdhhs.gov and select Providers. Then, choose fee schedule or manual.*

Covered Healthy Blue Medical Services

- For all covered services, there is no patient liability.
- Review the member's handbook or Provider Office Manual for a full list.

Service	Prior Authorization	Limitations or Notes
Abortions	Yes	Only covered when needed to save the mother's life or as the result of rape or incest.
Ambulance	No	Only covered for emergency transportation to the hospital (land or air).
Audiology	No	For children under 21, hearing aids, exams, ear molds and preventive and corrective services are included. For adults 21 and over, cochlear implant placement, replacement and maintenance is covered.
Chiropractic	Yes	Only covers medically necessary services, limited to services using hands to put the bones of the spine back in line. Member is allowed up to six visits per benefit year.
Chronic renal disease/dialysis	No	Includes hemodialysis, peritoneal dialysis and other dialysis procedures for members with kidney problems.
Communicable disease	No	Includes exams, education, counseling, contact tracing and certain outreach.
Diabetic supplies	Yes	Pharmacy and medical benefit covers glucose monitors, test strips and lancets. Medical benefit covers one pair of diabetic shoes per year, three pairs of diabetic shoe inserts per year and insulin pumps for Type 1 diabetes.
Durable medical equipment	Varies per item	Includes medical equipment that can be used more than once, and disposable supplies that cannot be used again and are thrown away when medically necessary and used by a person who is sick or injured.

Covered Healthy Blue Medical Services (Continued)

Service	Prior Authorization	Limitations or Notes
Family planning	No	Includes medical visits for birth control, counseling, nontherapeutic sterilizations, birth control, pregnancy tests, lab services and STI tests.
FQHC and RHC	No	Includes preventive care and primary care.
Home health care	Yes	Members get up to 50 visits per calendar year. Includes home health aides, medical supplies and equipment for use in the home, and physical, occupational and speech therapy.
Hospital – inpatient	Yes	Limited to general acute hospital services listed in the member's handbook. Private rooms are not covered unless medically necessary.
Hospital – outpatient	Yes	Refer to the services listed in the member's handbook.
Hysterectomies	Yes	Covered when they are nonelective and medically necessary.
Institutional long-term care	Yes	Covers the first 90 days or until the member is disenrolled from the plan when approved for and admitted to a long-term care facility or nursing home. After 90 days, SC Healthy Connections Medicaid will cover until the member receives regular Medicaid.
Lab and x-ray	Varies	Includes labs and x-rays ordered by the doctor and done by a licensed provider. Members must use a network participating lab or facility, and the services must be medically necessary.
Physician (doctor) care	No	Includes visits with PCPs, specialists, and other providers.
Podiatry	Yes	Only covered when medically necessary and includes medical and surgical treatment or disease, injury or defects of the foot, and routine foot care such as cutting or removing corns and calluses.

Covered Healthy Blue Medical Services (Continued)

Service	Prior Authorization	Limitations or Notes
Smoking/tobacco cessation	No	Includes FDA-approved medication and one-one-one telephone and web-based counseling, as well as individual and group counseling, limited to four sessions per quit attempt and two quit attempts per year.
Therapy (Physical, occupational and speech)	Varies	Members older than 21 years have a limit of 75 combined visits per benefit year. Members 21 years and younger who receive therapy from a private practitioner are limited to 105 combined hours or 420 units per benefit year. **More visits, hours or units may be approved if medically necessary.
Vaccines	No	Includes FDA-approved vaccines.
Vision	No	Covered through Vision Service Plan (VSP). For members 21 years of age and older, includes one eye exam every 12 months and one pair of eyeglasses (frames and lenses) and related fitting every 24 months. For members under 21 years of age, includes one eye exam every 12 months and one pair of eyeglasses (frames and lenses) and related fitting every 12 months.
Well-woman	No	Female members can receive routine and preventive care from a women's health specialist, such as an OB/GYN/

Benefit Partners

DentaQuest®, VSP and Healthy Connections

- **DentaQuest**
  - Provides dental coverage for members age 21 and under
  - Providers can get benefit details by:
    - Phone: 888-308-6552
    - Web: www.dentaquest.com
- **VSP**
  - Provides vision coverage for members Healthy Blue members.
  - Providers can get benefit details by:
    - Phone: 800-877-7195
    - Web: www.vsp.com
- **Healthy Connections**
  - Allows members to make updates to their address, report changes to the health plan and review the services covered by Medicaid
  - Members can contact Healthy Connections by:
    - Phone: 888-549-0820 (TTY: 888-842-3620)
    - Web: www.scdhhs.gov

Relay South Carolina and Modivcare

- **Relay South Carolina**
  - Offers communication assistance services to Healthy Blue members who are deaf, deaf-blind or hard of hearing, and those with speech disabilities
  - Members can contact Relay South Carolina by:
    - Phone: 800-735-2583 (or dial 711)
    - Web: www.relaysouthcarolina.com
- **Modivcare**
  - Offers transportation for non-emergent medical services to Healthy Blue members
  - Requests must be made at least three days before the appointment
  - Available Monday through Friday, from 8 a.m. to 5 p.m., EST
  - Providers can contact Modivcare by:
    - Phone: Numbers differ by region (view the map on the website)
    - Web: www.modivcare.com/facilities/sc

Provider Incentives

Note: All provider incentives only apply to PCPs.

Notification of Pregnancy Provider Incentive

- Incentive of $200
- Include date of pregnancy diagnosis, CPT 99080, modifier 32 and billed charges of $200
- Pregnancy Notification Report must be completed and faxed to 866-387-2974 within seven business days from the pregnancy diagnosis date

CenteringPregnancy Provider Incentive

- Incentive up to $475
- CPT 99078:
  - Include modifier TH, an E&M code (up to 10 visits), pregnancy diagnosis and billed charges of $30
- CPT 0502F:
  - Include modifier TH, an E&M code (billed with or after fifth visit), pregnancy diagnosis and billed charges of $175

Screening, Brief Intervention and Referral to Treatment Provider Incentive

- Screening
  - Incentive of $24
  - Include date of screening, CPT H0002, modifier HD (if positive) and billed charges of $24
- Brief Intervention
  - Incentive of $48
  - Include date of screening, CPT H0004, modifier HD (if referral given) and billed charges of $48

Well Child Provider Incentive

- Incentive of $60
- Include date of well-child exam, CPT G9153 and billed charges of $60

Well-infant: Members who will turn one (12 months) to 15 months within the current year

CPT/HCPCS	Modifier	ICD-10
99381-99385, 99391-99395, 99461, G0438-G0439	EP	Z00.0X, Z00.1XX, Z00.X, Z02.X, Z02.71, Z02.79, Z02.8X

Well-child: Members who will turn three to six years old within the current year

CPT/HCPCS	Modifier	ICD-10
99381-99385, 99391-99395, 99461	EP	Z00.0X, Z00.1XX, Z00.X, Z02.X, Z02.71, Z02.79, Z02.8X

Adolescent well-child: Members who will turn 12 to 20 years old within the current year

CPT/HCPCS	Modifier	ICD-10
99461, 99381-99385, 99391-99395	EP	Z00.0X, Z00.1XX, Z00.X, Z02.X, Z02.71, Z02.79, Z02.8X, Z02.9

Sports Physical Provider Incentive

- Incentive of $30
- Include date of sports physical, CPT 99212, modifier 8P, diagnosis Z02.5 and billed charges of $30
- Available for members ages six to 18
- Can be billed with well-child exam if the member has not received a well-child in the current benefit year

CPT Category II Codes Provider Incentive

- Incentive varies per code
- Once per member, once per service, once per year
- Each code has diagnosis, age and criteria requirements
- List of codes available on Healthy Blue website

Behavioral Health

Fee-for-Service for Behavioral Health

- South Carolina Department of Health and Human Services (SCDHHS) is an independent organization that offers helpful health information and is responsible for:
  - Some behavioral health services.
  - Waiver services.

Covered Behavioral Health Services

- Inpatient services provided in a general acute care hospital.
- Professional psychiatric services.
- Outpatient services provided by;
  - Licensed independent practitioners (LIPs)
  - Group practices
  - Federally qualified health centers (FQHCs)
  - Rural health clinics (RHCs) including psychiatrists and advanced nurse practitioners
- Substance abuse services provided by any of the Office of Substance Use Services
- Autism services
- Psychiatric Residential Treatment Facility (PRTF)
  - Per diem updated from $500 to $525 on July 1, 2024
- Rehabilitative Behavioral Health Services (RBHS)
- Opioid Treatment Program (OTP)
- Institutes for Mental Disease (IMD)

Additional Covered Behavioral Health Services

- School-based Mental Health
- Assertive Community Treatment Services
- Multisystemic Therapy
- Hospital-based Crisis Stabilization Services
- Intensive In-home Supports: Evidence-based and Homebuilders Services
- Transplant and Development Evaluation Centers
- Office of Substance Use Services/301s and Medical Services
- Peer Support Services
- Targeted Case Management
- ASD – Phase II
  - Added codes 97152, 97157, 0362T and 0373T
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)

Checking Covered Codes for Behavioral Health

- All Healthy Blue behavioral health providers are encouraged to review manuals on the SCDHHS website for information on covered codes and limitations.
- Manuals for behavioral health include:
  - Autism Spectrum Disorder (ASD) Services
  - Community Mental Health (CMH) Services
  - FQHC Behavioral Health Services
  - Local Education Agencies (LEA) Services
  - LIPs Rehabilitative Services
  - Psychiatric Hospital Services
  - RBHS

Inpatient Behavioral Health

- Inpatient behavioral health services are only covered if provided in a contracted and credentialed:
  - General acute care hospital
  - Office of Substance Use Services
  - Free-standing psychiatric facility
- Diagnosis-related group (DRG) coverage include:
  - DRG 424-433: Psychiatric services
  - DRG 521-523: Substance abuse services
- Prior authorization is required.

Outpatient Behavioral Health

- Outpatient behavioral health services are covered when provided in a solo or group practice, FQHC or RHC.
- The following contracted and credentialed practitioners can provide services:
  - Psychiatrists
  - Psychologists
  - Master-level nurses
  - Licensed master social workers (LMSW) under the supervision of a contracted and credentialed physician, psychologist or independently licensed master-level behavioral health provider
  - Independently licensed master-level clinicians
  - Licensed independent social workers (LISW)
  - Licensed professional counselors (LPC)
  - Licensed marriage and family therapists (LMFT)
  - Licensed psychoeducational specialists (LPES)
- LIP providers can provide mental health and substance abuse counseling services.

Outpatient Behavioral Health Authorizations

- To get prior authorization, use My Insurance Manager.
  - You will be routed to the Cohere Health Platform.
    - All clinical decisions are made by Healthy Blue.
- Prior authorization is required for codes 90832, 90834 and 90837 after 24 sessions within a billing period.
  - Includes all sessions, regardless of the provider.
  - Billing period runs from July 1 to June 30.
- Psychological testing and assessments require prior authorization.
- Services deemed by DHHS to be community support services require prior authorization. These include:
  - Psychosocial rehabilitation services.
  - Behavior modification.
  - Family support.
  - Therapeutic child and foster care.
  - Community integration services.
  - Peer support services.

School-based Mental Health

- SCDHHS provides Medicaid reimbursement for medically necessary services provided to Medicaid-eligible individuals in local education agencies (LEA).
- Medical necessity means the need for treatment is:
  - Necessary to diagnose, treat, cure, or prevent an illness.
  - Reasonably expected to relieve pain, improve and preserve health.
  - Essential to life.
- This includes, but is not limited to, children under the age of 21 who have or are at risk of developing sensory, emotional, behavioral or social impairments, physical disabilities, medical conditions, intellectual disabilities, or developmental disabilities or delays.

Billing for School-based Mental Health

- Billing modifiers must match the credentials of the individual rendering the service.
  - H1: Licensed Clinician
    - Licensed clinician refers to licensed or certified professionals allowed to practice at the independent level. This includes: LPC, LMFT, LISW, LPES, certified school psychologist II and III.
  - H2: Unlicensed Clinician
    - Unlicensed clinician refers to professionals who require supervision and co-signature on their diagnostic assessments (used to confirm medical necessity). This includes: LMSW, MHP and certified school psychologist I.
- Use place of service 03.
  - When submitting claims electronically, this must be entered in the 2300 NTE segment.
  - When submitting claims through My Insurance Manager, include this on the Claim Information page.

Staffing Supervision for School-based Mental Health

- Services provided by and LMSW or unlicensed MHP must be clinically supervised by a licensed practitioner of healing arts.
- Supervising licensed professionals must have a log documenting supervision of services by the LMSW or MHP.
- Supervision must occur at a minimum of every 30 days.

Office of Substance Use Services

- All Office of Substance Use Services Commissions are contracted and credentialed with Healthy Blue.
- Services are based on the American Society of Addiction Medicine (ASAM) levels of care.
- Managed care organizations review care based on the ASAM medical necessity criteria.
- Medication-assisted treatment (MAT) services delivered as defined in the clinical services manual, do not require prior authorization.

Office of Substance Use Services Levels of Care

1. Residential detoxification
2. Social detoxification
3. Medically monitored inpatient detoxification
4. Residential treatment
5. Day treatment or partial hospitalization
6. Intensive outpatient treatment
7. Outpatient treatment

Rehabilitative Behavioral Health Services

- RBHS can be rendered by the following provide types:
  - LIPs
  - LACs
  - Office of Substance Use Services
  - Office of Mental Health; provided directly
  - South Carolina Department of Education (DOE); provided directly
  - South Carolina Department of Juvenile Justice (DJJ)
  - South Carolina Department of Social Services (DSS)
  - South Carolina Continuum of Care (COC)
- Prior authorization is required for all services and providers.

Assertive Community Treatment

- ACT services are covered by SCDHHS.
- ACT provides a team approach to coordinate care through community-based behavioral health treatment, rehab and support of individuals with serious and persistent mental illness.
- Services are offered 24-hours per day, seven days per week, in a community-based setting which could include the member’s home, shelter, or even on the street.

Multisystemic Treatment

- MST services are covered by SCDHHS.
- MST addresses the externalizing behaviors of youth with troublesome behavior, mood, or substance use concerns.
- Services are offered in the home, school, or community for youth ages 12 to 17 who are at risk of court involvement or home displacement.

Note: Exceptions can be made for ages 10, 11 or 18 with approval. Review the RBHS manual for more details.

Autism Spectrum – Treating New Patients

- Prior authorization is required for all new Healthy Blue members.
- To request the authorization, use My Insurance Manager.
- For faxed requests, submit the following information to 803-870-6506:
  - Diagnosis of autism
  - Plan of care
  - CPT codes requested
- Allow up to 14 days for review and notice.

Autism Spectrum Providers

- Autism spectrum disorder providers include:
  - Licensed psychologists (PhD, PsyD)*
  - LPES*
  - LISW
  - LMFT
  - LPC
  - Board-certified behavior analysts (masters or doctoral)
  - Board-certified assistant behavior analysts
  - Licensed physicians (MD, DO)*

**These are only the providers that can administer comprehensive diagnosis assessments.*

Extra Benefits

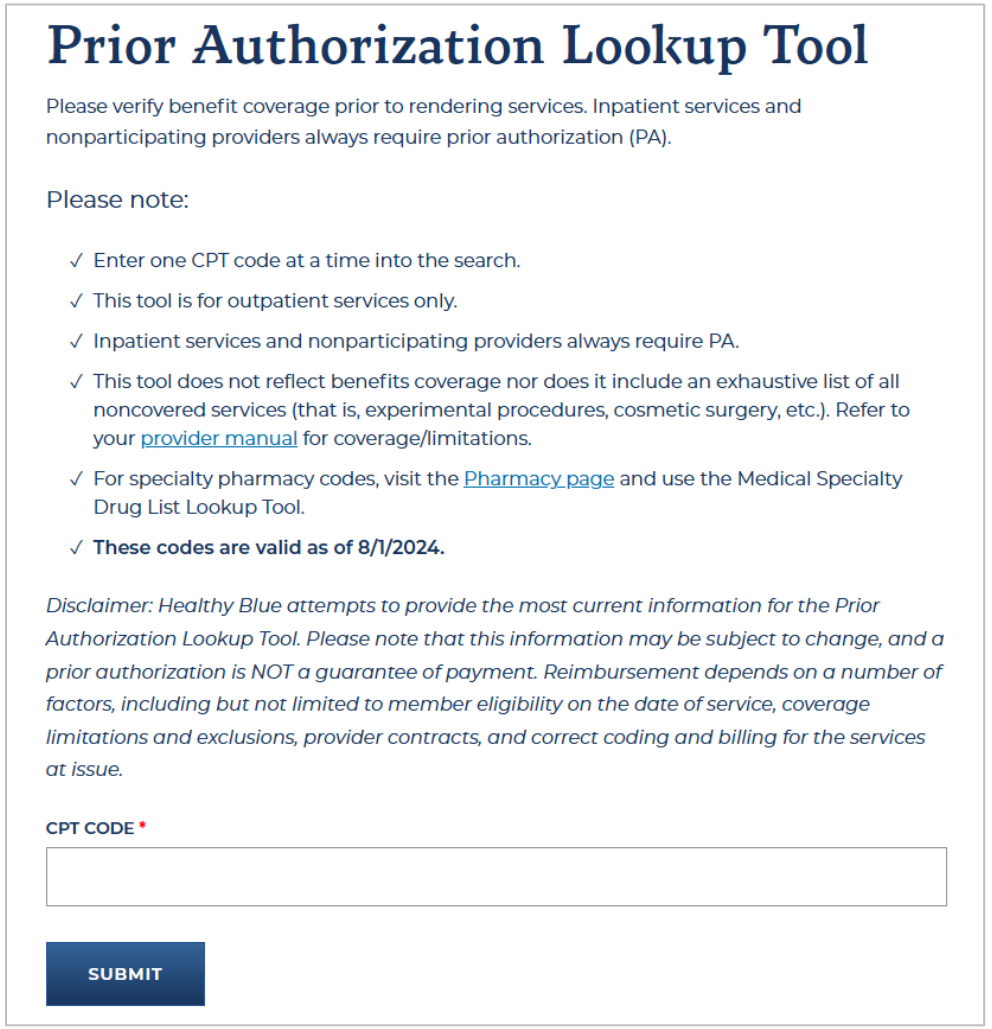
- Extra benefits are additional services offered to Healthy Blue members that are not included in the core benefits and are not funded by Medicaid dollars.
- There are extra benefits that only apply to children, pregnant members or new parents, adults, members in care management, and all members.
- A full list is available on the website, but some include:
  - Girl Scouts membership
  - Boys & Girls Club fees
  - Tutoring support
  - Infant car seats
  - Diapers for babies
  - GED Ready® assessment exam fee
  - Uber or Lyft Transportation
  - Diabetic nutritional program
  - Blue365

Authorizations

Authorization Lookup Tool

- The prior authorization lookup tool is used for outpatient services only.
  - There is a lookup tool for medical, behavioral health and pharmacy services.
    - Requirements may vary per code.
- Be sure to verify benefits and eligibility before rendering services.

Note: Refer to the Authorizations section of our website, www.HealthyBlueSC.com, for additional details. Providers>Authorization and Eligibility>Prior Authorization



Prior Authorization Lookup Tool

Please verify benefit coverage prior to rendering services. Inpatient services and nonparticipating providers always require prior authorization (PA).

Please note:

- ✓ Enter one CPT code at a time into the search.
- ✓ This tool is for outpatient services only.
- ✓ Inpatient services and nonparticipating providers always require PA.
- ✓ This tool does not reflect benefits coverage nor does it include an exhaustive list of all noncovered services (that is, experimental procedures, cosmetic surgery, etc.). Refer to your provider manual for coverage/limitations.
- ✓ For specialty pharmacy codes, visit the Pharmacy page and use the Medical Specialty Drug List Lookup Tool.
- ✓ **These codes are valid as of 8/1/2024.**

Disclaimer: Healthy Blue attempts to provide the most current information for the Prior Authorization Lookup Tool. Please note that this information may be subject to change, and a prior authorization is NOT a guarantee of payment. Reimbursement depends on a number of factors, including but not limited to member eligibility on the date of service, coverage limitations and exclusions, provider contracts, and correct coding and billing for the services at issue.

CPT CODE *

SUBMIT

Authorization Lookup Tool Medical Examples

Prior Authorization Lookup Tool

Please verify benefit coverage prior to rendering services. Inpatient services and nonparticipating providers always require prior authorization (PA).

Please note:

- ✓ This tool is for outpatient services only.
- ✓ Inpatient services and nonparticipating providers always require PA.
- ✓ This tool does not reflect benefits coverage nor does it include an exhaustive list of all noncovered services (that is, experimental procedures, cosmetic surgery, etc.). Refer to your provider manual for coverage/limitations.
- ✓ **These codes are valid as of 7/1/2024.**

CPT CODE *

99203

SUBMIT

No prior authorization required.

Prior Authorization Lookup Tool

Please verify benefit coverage prior to rendering services. Inpatient services and nonparticipating providers always require prior authorization (PA).

Please note:

- ✓ This tool is for outpatient services only.
- ✓ Inpatient services and nonparticipating providers always require PA.
- ✓ This tool does not reflect benefits coverage nor does it include an exhaustive list of all noncovered services (that is, experimental procedures, cosmetic surgery, etc.). Refer to your provider manual for coverage/limitations.
- ✓ **These codes are valid as of 7/1/2024.**

CPT CODE *

s9131

SUBMIT

S9131

Yes, Precertification is required.

Physical therapy, in the home, per diem

Prior Authorization Lookup Tool

Please verify benefit coverage prior to rendering services. Inpatient services and nonparticipating providers always require prior authorization (PA).

Please note:

- ✓ This tool is for outpatient services only.
- ✓ Inpatient services and nonparticipating providers always require PA.
- ✓ This tool does not reflect benefits coverage nor does it include an exhaustive list of all noncovered services (that is, experimental procedures, cosmetic surgery, etc.). Refer to your provider manual for coverage/limitations.
- ✓ **These codes are valid as of 7/1/2024.**

CPT CODE *

92508

SUBMIT

92508

Precertification is required after limit met, contact provider services for benefit limit information.

Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals

No until service limits met

Authorization Lookup Tool Behavioral Health Examples

CPT CODE *

h2014

SUBMIT

H2014

Yes, Precertification is required.

Skills training and development, per 15 minutes

CPT CODE *

90832

SUBMIT

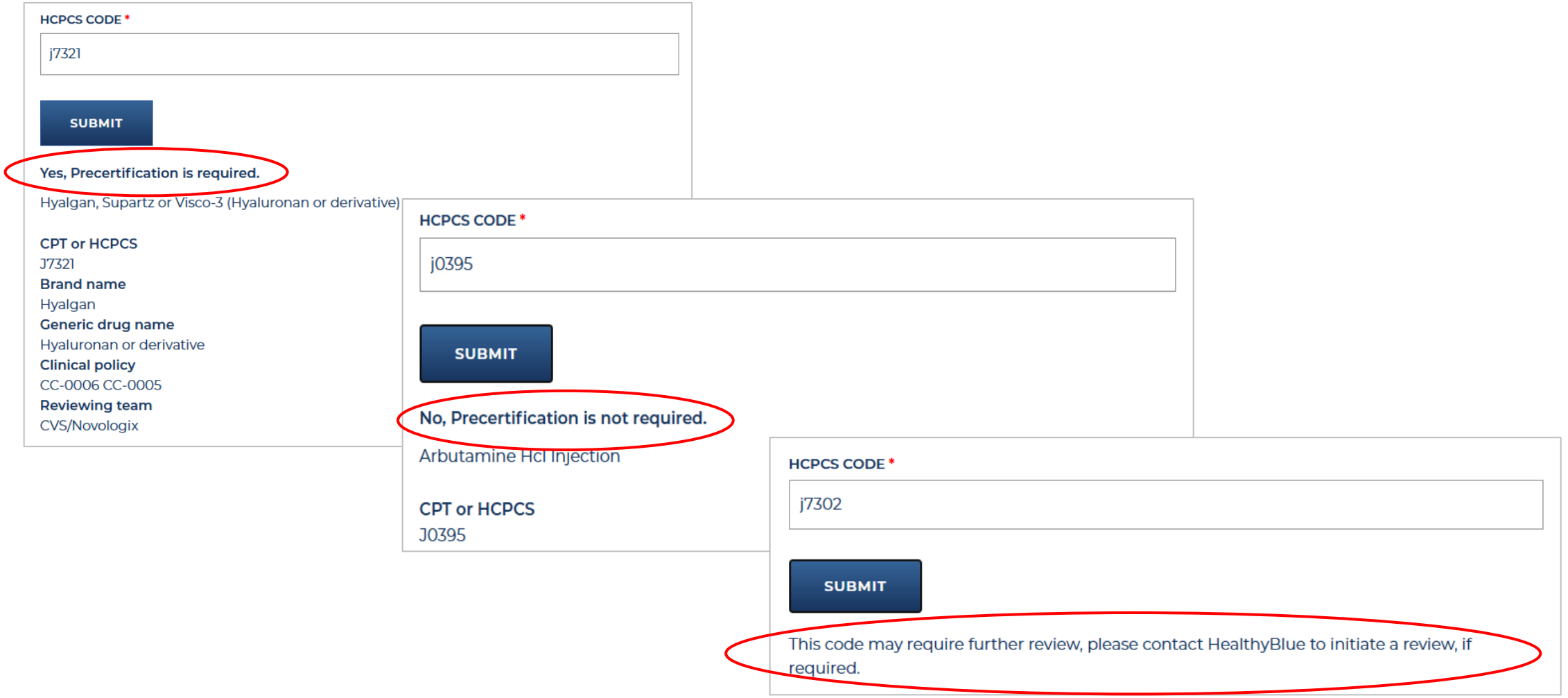
90832

Precertification is required after limit met, contact provider services for benefit limit information.

Individual Psychotherapy, 30 mins

No until service limits met

Authorization Lookup Tool Pharmacy Examples

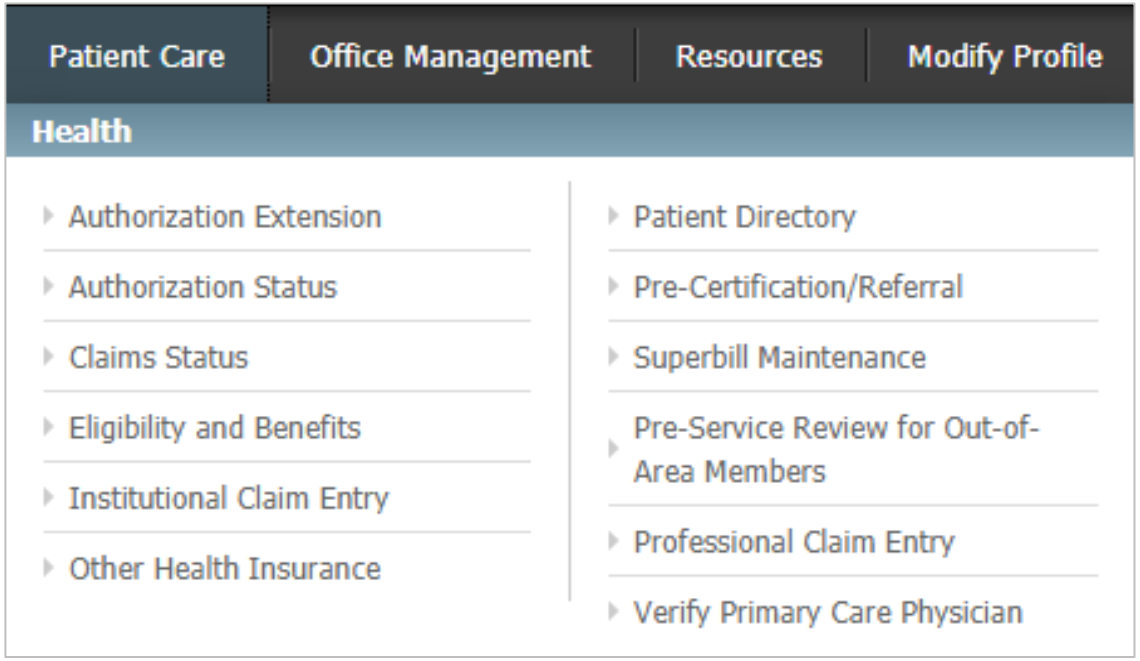


Required Information for Authorizations

- Patient Details
  - Name
  - Medicaid ID number
  - Date of birth
- Service Details
  - CPT or HCPCS codes
  - Diagnosis codes
  - Date of service
- Location Details
  - Facility
    - Name
    - Address
    - Tax ID or NPI
  - Rendering
    - Name
    - Address
    - Tax ID or NPI
- Contact Information
  - Phone number
  - Fax number
  - Email
- Clinicals
  - Length of issue
  - Attempted treatment
  - Conservative medications
  - Studies (i.e., labs, imaging)

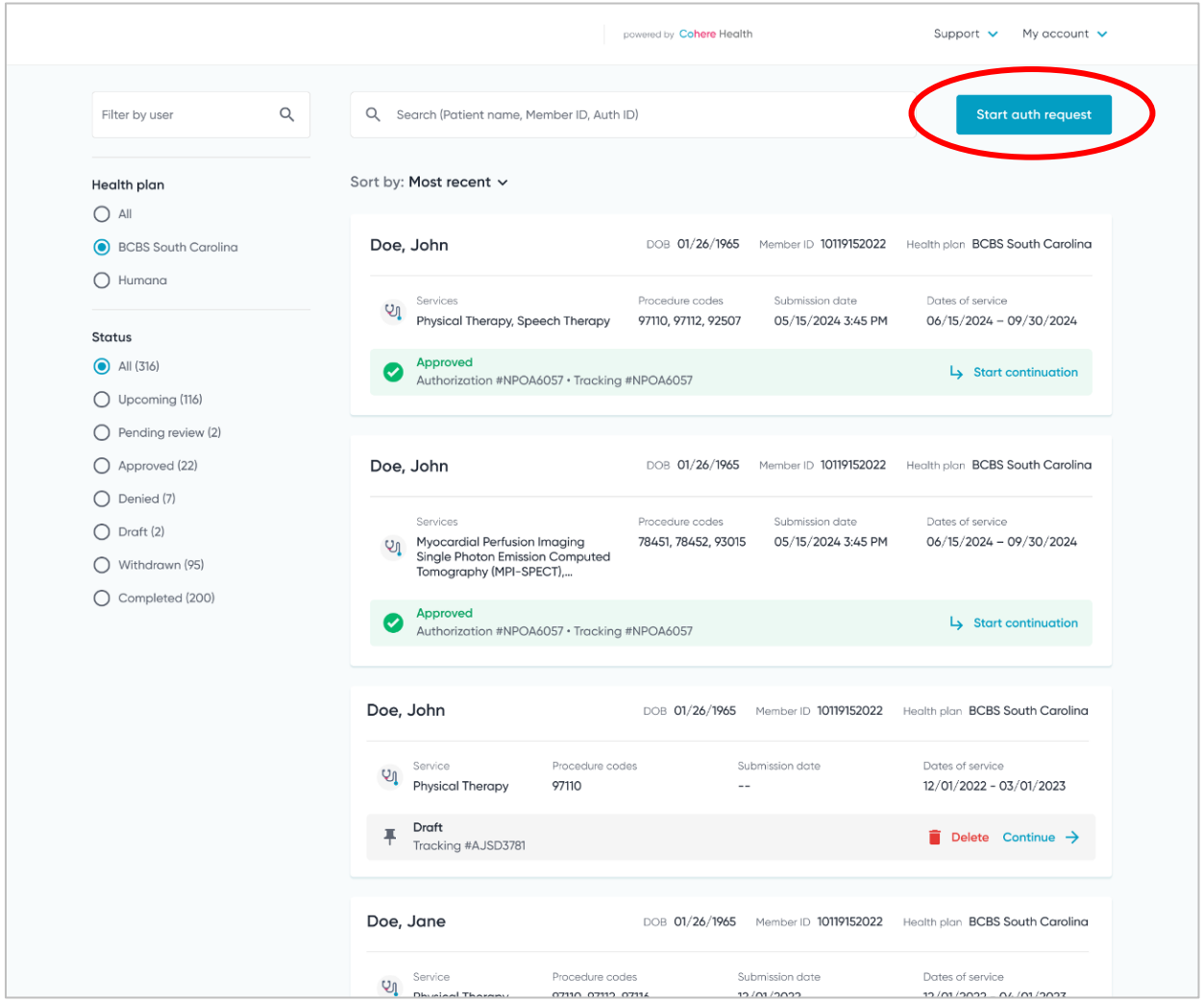
Submitting an Authorization Request – Medical and Behavioral Health

- Requests for prior authorization for Healthy Blue should be done using My Insurance Manager.
  - You will be routed to the Cohere Health Platform.
    - All clinical decisions are made by Healthy Blue.
- Under Patient Care, select Pre-certification/Referral.



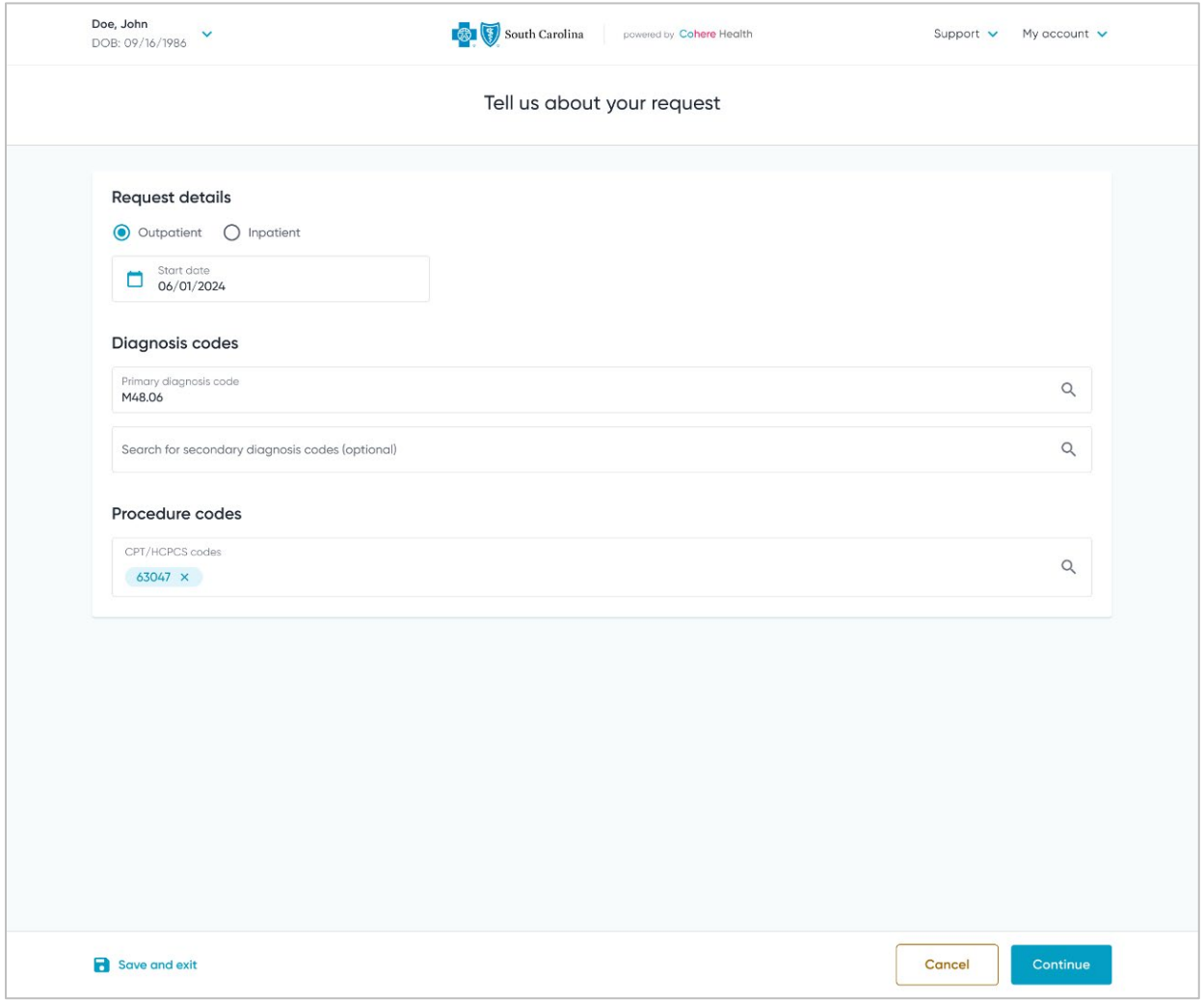
Cohere Health Landing Page

- When you reach the landing page of the new platform, you will see a full listing of authorizations under your tax identification number (TIN).
- The authorizations can be filtered by:
  - All
  - Upcoming
  - Pending review
  - Approved
  - Denied
  - Draft
  - Withdrawn
  - Completed
- You can also search for a specific patient or authorization.
- To start a new request, select Start auth request.



Cohere Health – Information About Request

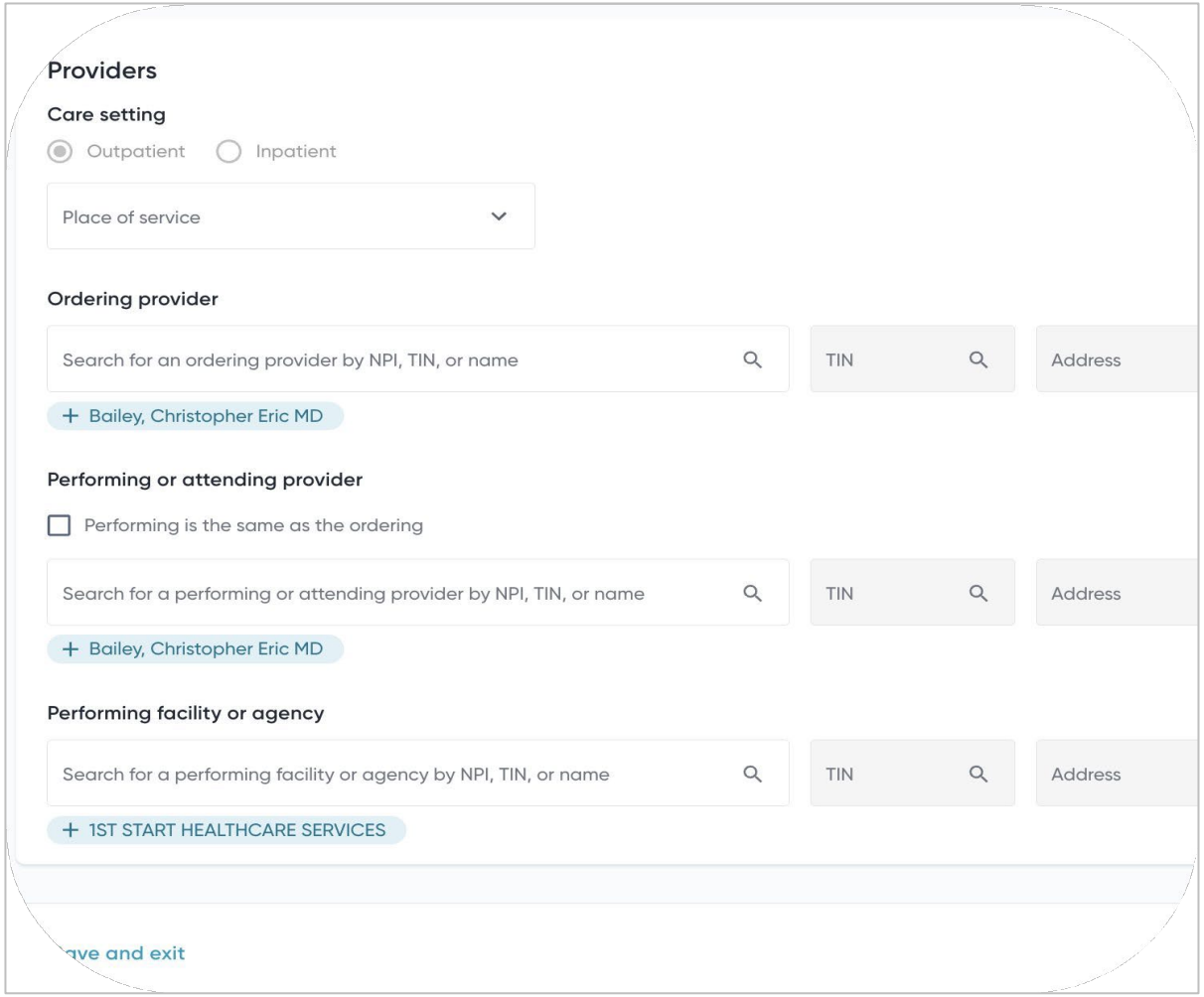
- Select whether the service is outpatient or inpatient.
- Include the diagnosis and procedure code(s).
- Select Continue.



Note: You have the option to save and exit the request at any time. You can also cancel the request if it's no longer needed.

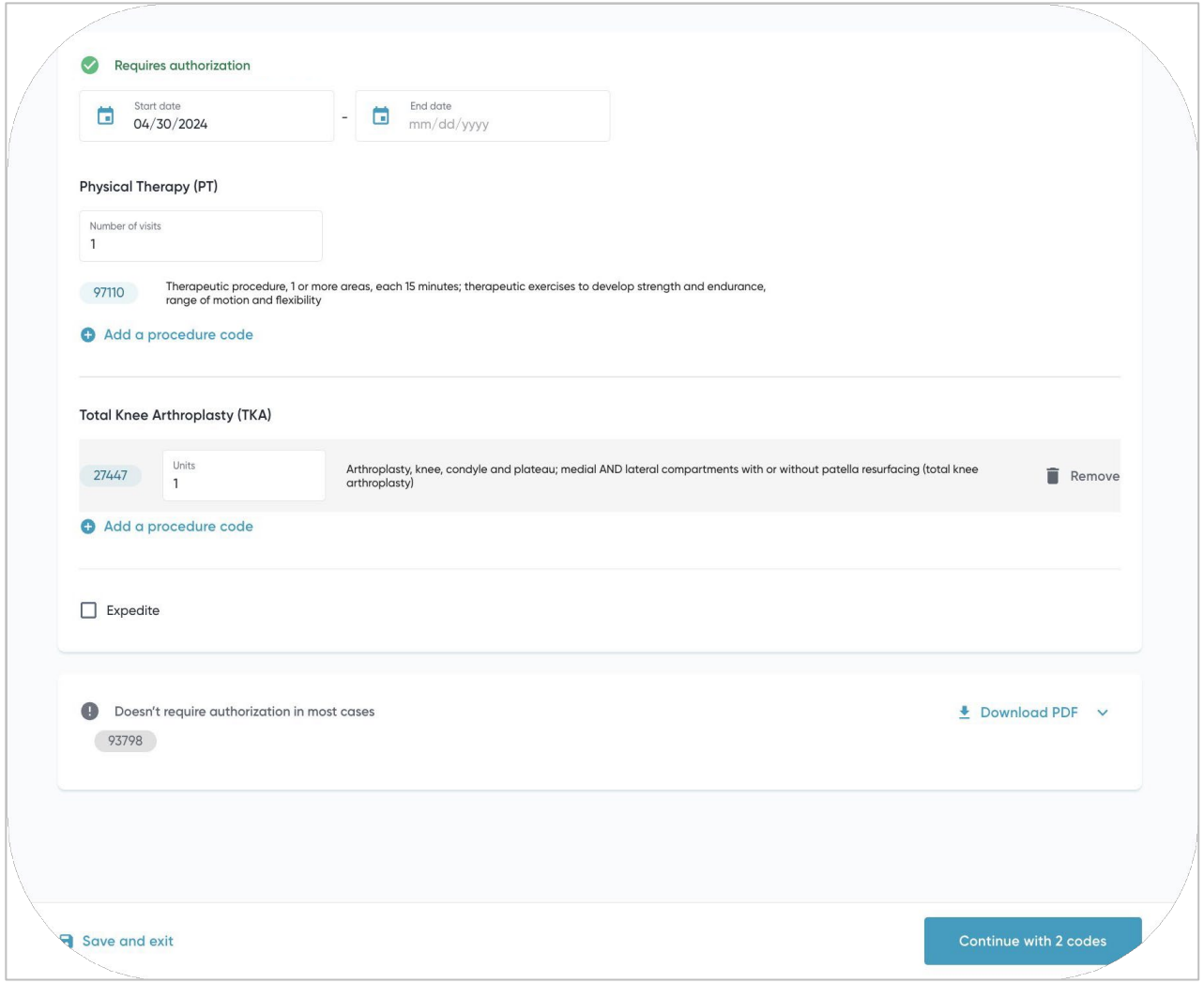
Cohere Health – Provider Details

- Enter the provider details to include:
  - Ordering provider.
  - Performing or attending provider.
  - Performing facility or agency.
- There is a TIN search feature to make the process easier.
- Select Continue.



Cohere Health – Determination

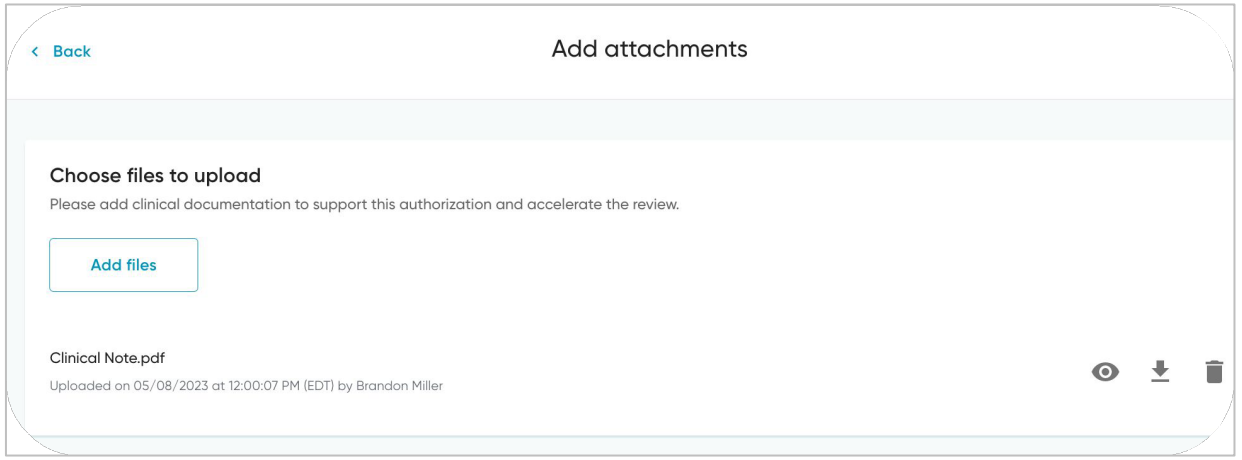
- On this screen, the top portion will tell you which codes you requested require authorization.
- The bottom portion will tell you which codes do not require authorization.
- There’s an option to expedite the request if it’s an urgent matter.
- Select Continue.



Note: The continue option will indicate the number of codes being requested for review.

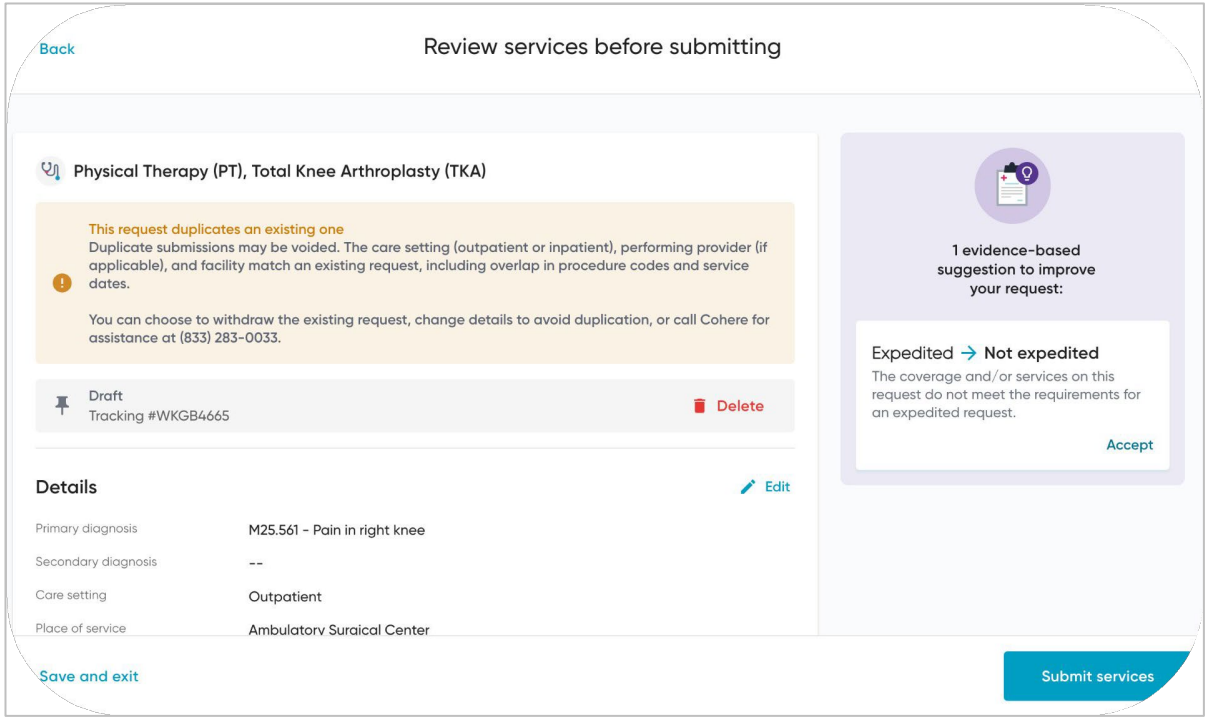
Cohere Health – Clinicals

- Upload all relevant clinical documentation for review.
- You will have the option to review the uploaded items or remove them.
- Select Continue.



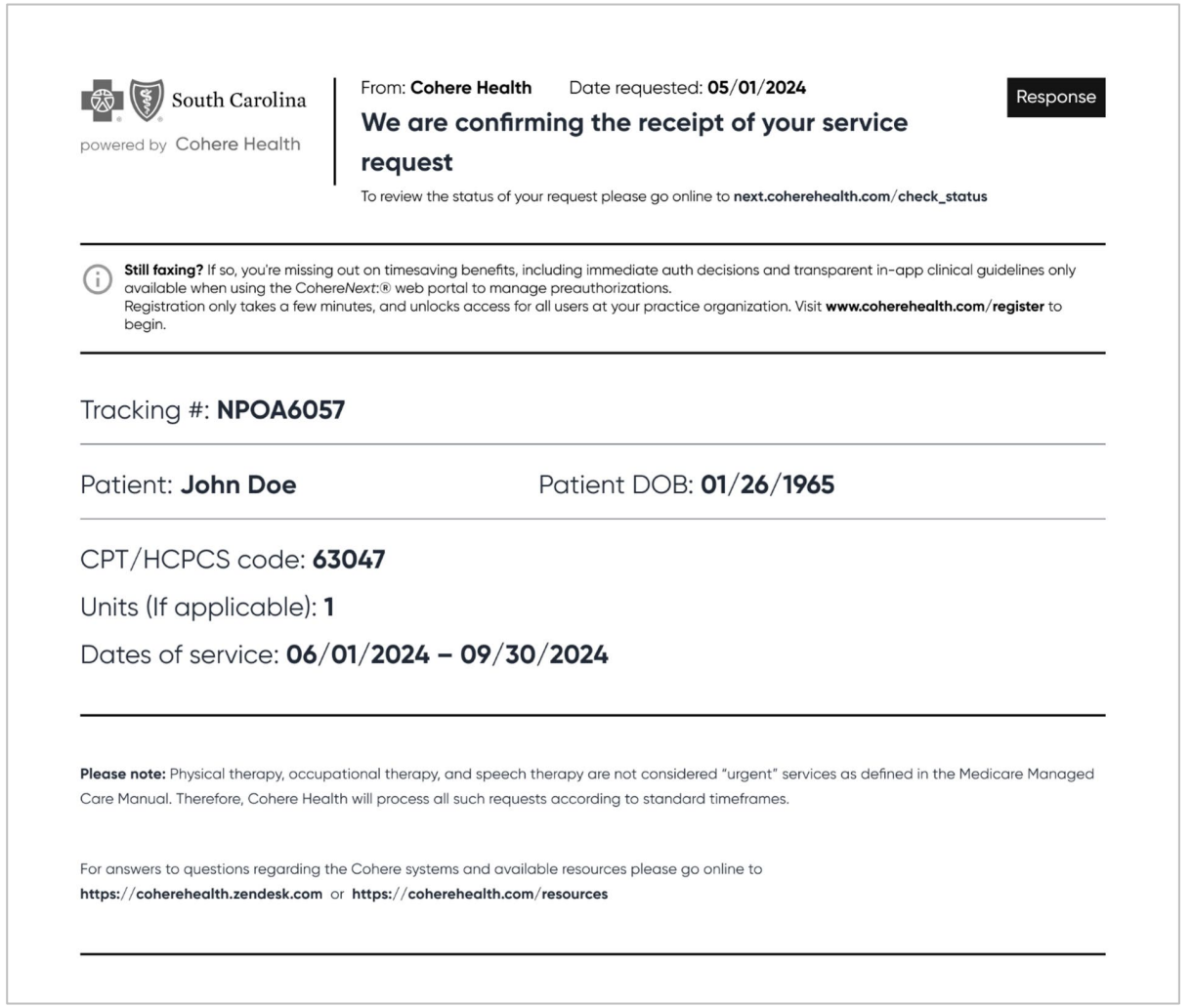
Cohere Health – Submitting Request

- Review all the relevant information.
- If the request is a duplicate, you will be notified that there is an existing case on file, and that it's a possibility that the duplicate submission may be voided. If you receive this message, we encourage you to review the existing authorizations for the patient before moving forward.
- Secondly, if you previously checked the box to expedite your request, but there is no evidence supporting the need for the request to be expedited, you will receive a notice suggesting that you change the request to "not expedited." With this you can either accept the suggestion or leave it as is and proceed with submission.
- Select Submit services.



Cohere Health – Confirmation

- After submitting the request, you will receive a faxed notification confirming the receipt of your service request.
- This notification will include the tracking number assigned to the request by Cohere Health.
- Please be mindful that this tracking number is not the authorization number. The purpose of the tracking number is to simply allow you to follow up on the process inside the platform.
- If the authorization request is approved, you will be provided with the authorization number, which is what should be included with your claim.



South Carolina
powered by Cohere Health

From: **Cohere Health** Date requested: **05/01/2024**

Response

We are confirming the receipt of your service request

To review the status of your request please go online to **next.coherehealth.com/check_status**

Still faxing? If so, you're missing out on timesaving benefits, including immediate auth decisions and transparent in-app clinical guidelines only available when using the Cohere*Next*:® web portal to manage preauthorizations.
Registration only takes a few minutes, and unlocks access for all users at your practice organization. Visit **www.coherehealth.com/register** to begin.

Tracking #: **NPOA6057**

Patient: **John Doe** Patient DOB: **01/26/1965**

CPT/HCPCS code: **63047**

Units (If applicable): **1**

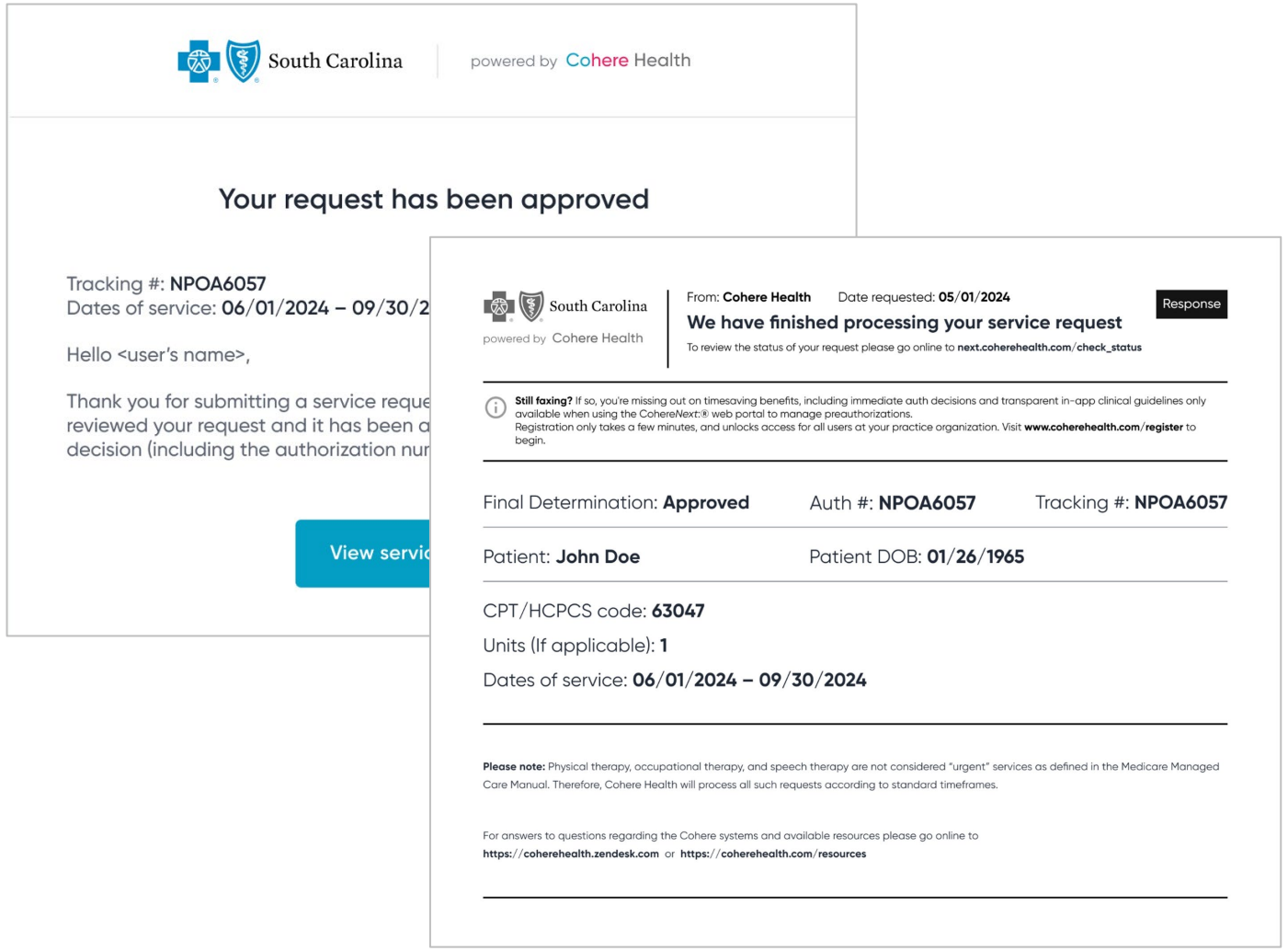
Dates of service: **06/01/2024 – 09/30/2024**

Please note: Physical therapy, occupational therapy, and speech therapy are not considered "urgent" services as defined in the Medicare Managed Care Manual. Therefore, Cohere Health will process all such requests according to standard timeframes.

For answers to questions regarding the Cohere systems and available resources please go online to **https://coherehealth.zendesk.com** or **https://coherehealth.com/resources**

Cohere Health – Notifications

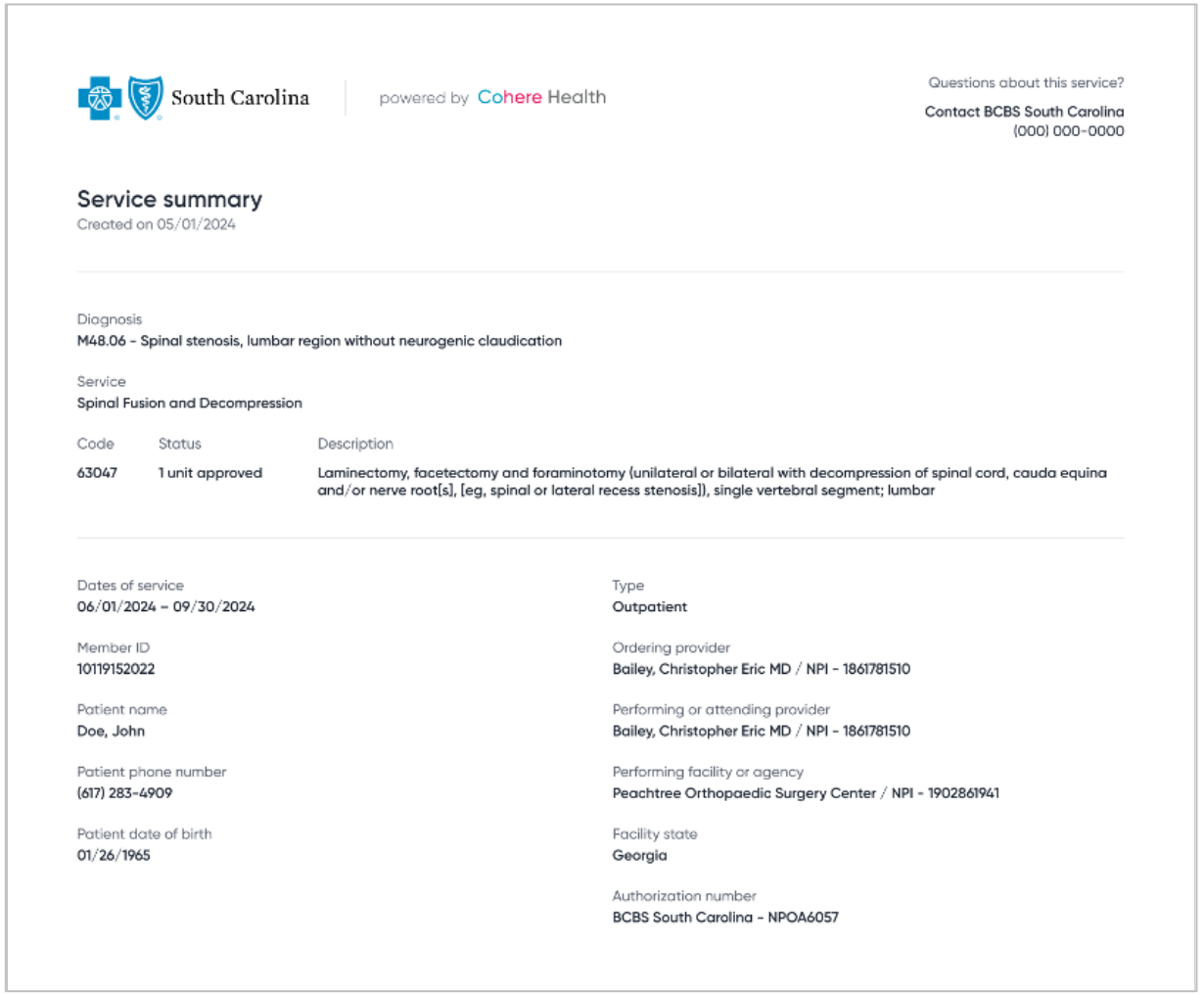
- You will be notified once the authorization is approved.
  - Portal notification
  - Faxed notification
- To view additional details, select View service summary inside the portal.



Note: You will also receive a notice if the request is denied.

Cohere Health – Service Summary

- The service summary will outline the requested authorization to include:
  - Diagnosis and procedure code(s).
  - Place of service.
  - Ordering provider.
  - Performing or attending provider.
  - Performing facility or agency.
  - Dates of service.



South Carolina | powered by Cohere Health

Questions about this service?
Contact BCBS South Carolina
(000) 000-0000

Service summary

Created on 05/01/2024

Diagnosis
M48.06 - Spinal stenosis, lumbar region without neurogenic claudication

Service
Spinal Fusion and Decompression

Code	Status	Description
63047	1 unit approved	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

Dates of service
06/01/2024 – 09/30/2024

Member ID
10119152022

Patient name
Doe, John

Patient phone number
(617) 283-4909

Patient date of birth
01/26/1965

Type
Outpatient

Ordering provider
Bailey, Christopher Eric MD / NPI - 1861781510

Performing or attending provider
Bailey, Christopher Eric MD / NPI - 1861781510

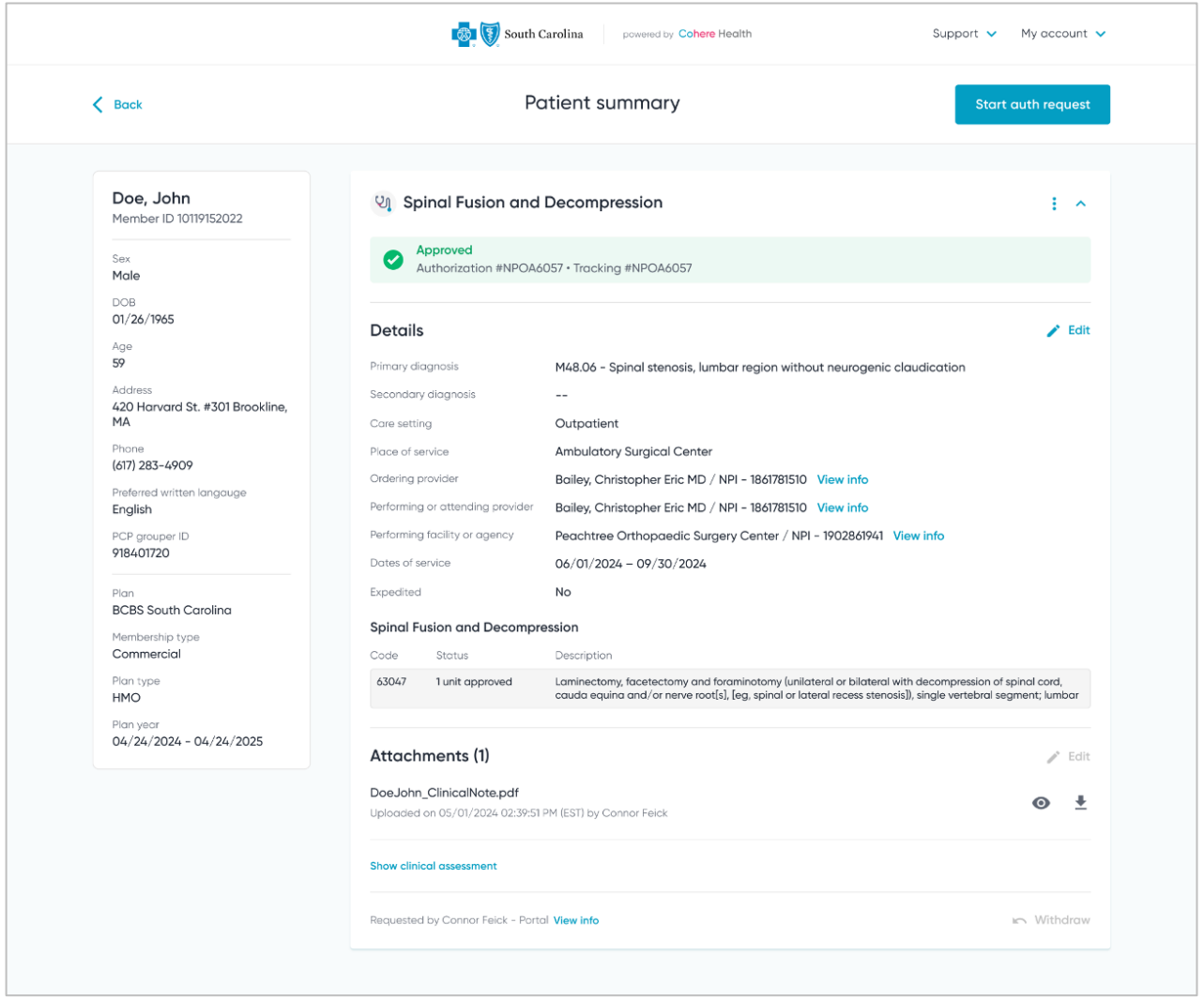
Performing facility or agency
Peachtree Orthopaedic Surgery Center / NPI - 1902861941

Facility state
Georgia

Authorization number
BCBS South Carolina - NPOA6057

Cohere Health – Patient Summary

- The patient summary will outline the same details as the service summary but will give you the option to view the clinical documentation that was provided.



Submitting an Authorization Request – Pharmacy

- Pharmacy Benefit – CarelonRx
  - Phone: 844-410-6890
  - Fax: 844-512-9005
  - ePA Portal: Covermymeds
  - Review time: 24 hours
- Medical Benefit – CVS/Novologix
  - Phone: 844-345-2803
  - Fax: 866-494-9927
  - Online Portal: My Insurance Manager
  - Review time: Urgent, 72 hours; Standard, 14 days

Claims

Ways to Submit Claims

- Providers have 365 days to submit an original or corrected claim.
- Claims can be submitted:
  - **Electronically (through your clearinghouse)***
    - Use payor ID 00403.
  - **Using My Insurance Manager**
    - Select Original Claim on the Claim Information page.
  - **By mail**
    - Use the appropriate address on the back of the member's ID card.

*Preferred method

Note: Refer to the Claims section of our website for additional details. Providers>Claims>Claims Submission

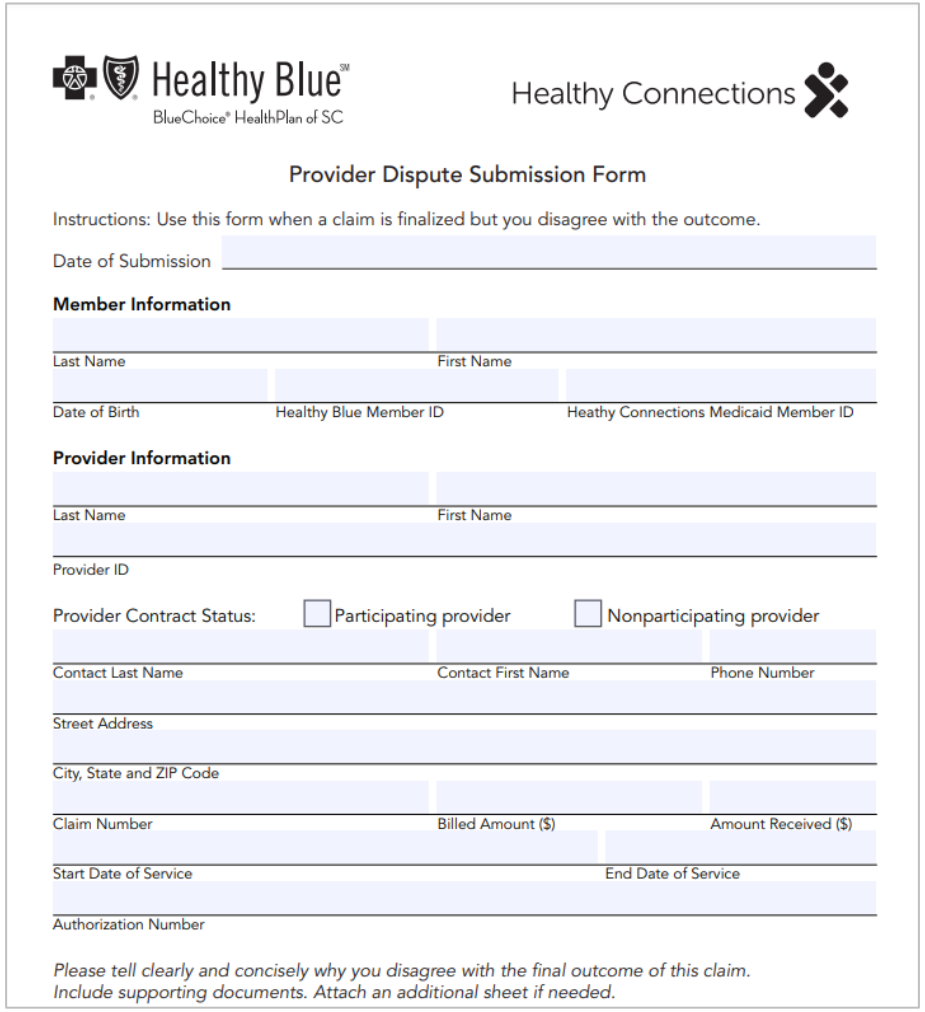
Getting Assistance with Claims

If you have questions on a claim, or feel like a claim processed incorrectly, use the following steps to get help. If you get a resolution at either step, you do not need to proceed to the next step.

- **Step 1**
  - Access My Insurance Manager
  - Review the claim thoroughly to understand the processing details
- **Step 2**
  - Call Provider Service at 866-757-8286
- **Step 3**
  - File a provider dispute

Submitting Provider Disputes

- Provider disputes must be submitted **within 90 calendar days** from the date of explanation of payment.
- Be sure to submit the appropriate Healthy Blue Provider Dispute Form when submitting your request.



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Provider Dispute Submission Form

Instructions: Use this form when a claim is finalized but you disagree with the outcome.

Date of Submission

Member Information

Last Name | First Name

Date of Birth | Healthy Blue Member ID | Heathy Connections Medicaid Member ID

Provider Information

Last Name | First Name

Provider ID

Provider Contract Status: ☐ Participating provider ☐ Nonparticipating provider

Contact Last Name | Contact First Name | Phone Number

Street Address

City, State and ZIP Code

Claim Number | Billed Amount ($) | Amount Received ($)

Start Date of Service | End Date of Service

Authorization Number

Please tell clearly and concisely why you disagree with the final outcome of this claim. Include supporting documents. Attach an additional sheet if needed.

Note: Refer to the Claims section of our website for additional details. Providers>Claims>Provider Dispute

How to Submit Provider Disputes

- **Verbally**
  - Call Provider Service at 866-757-8286
- **Email**
  - Send an email to HBProviderService@healthybluesc.com
- **Written**
  - Mail into Healthy Blue, Provider Dispute Unit, AX-570, P.O. Box 100317, Columbia, SC 29202-3317
- **In person**
  - Visit us at 4101 Percival Road, Columbia, SC 29229

Balance Billing

- Billing a member for an amount not reimbursed by Healthy Blue on a claim.
- Members should be held harmless and not responsible for amounts not paid for contracted services.

Overpayment Recovery

- If you receive a refund request or feel you received too much money, complete the Overpayment Refund Form to return the payment.
- Be sure to mail the form and check to the address listed on the form.

Note: Refer to the Claims section of our website for additional details. Providers>Claims>Refund Process

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Overpayment Refund Form

Use this form when sending Healthy Blue unsolicited or voluntary refund checks. Complete form and attach check and a copy of the remittance advice. Forward to address below.

To Be Completed by Physician's Office

Tax ID Number | Provider's Name

Provider's Address | Provider's Phone Number

Contact's Name

Check Number | Check Date | Amount of Check

Refund Information

Patient's Name | Patient's ID Number

Claim Number | Claim Amount Refunded

Reason for Refund

Choose refund reason or use space provided for explanation:

- ☐ Corrected date of service
- ☐ Duplicate payment
- ☐ Corrected code
- ☐ Not your patient
- ☐ Modifier added/removed
- ☐ Incorrect patient filed
- ☐ Services not rendered
- ☐ Member has primary insurance
  Insurance company name _____
  (attach EOB)
- ☐ Billed in error

Other:

Mail this form with check to:

Healthy Blue
Refunds Department (AX-480)
PO Box 100317
Columbia, SC 29202-3317

Healthy Blue is offered by BlueChoice HealthPlan, an independent licensee of the Blue Cross Blue Shield Association.

BCMC 217881-2-24

Mental Health Stigmas

Defining Mental Health Stigma

- Stigma refers to negative attitudes, beliefs, and stereotypes people may hold towards those who experience mental health conditions.
- Stigma can prevent or delay people from seeking care or cause them to discontinue treatment.
- We can all play a part in helping to reduce mental health stigma.

Forms of Mental Health Stigma

- **Structural stigma**: Involving laws, regulations, and policies that can limit the rights of those with mental health conditions.
- **Public stigma**: Includes negative attitudes and beliefs from individuals or from larger groups towards people with mental health conditions, or their families, or health care providers.
- **Self-stigma**: Comes from within the person with a mental health condition. People living with a mental health condition may believe they are flawed or blame themselves.

Reducing Mental Health Stigma

- Policies and practices that support people with a mental health condition, reducing barriers they face in the workplace and health care.
- Journalists, communicators and others in media working to educate the public responsibly about mental health.
- Treating those living with a mental health condition with understanding, empathy and acceptance.
- Having open conversations around mental health.

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3. National Academies of Sciences, Engineering, and Medicine. (2016). *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change*. National Academies Press (US).
4. National Institute of Mental Health. (n.d.). Stigma and discrimination toolkit. Retrieved on June 24, 2024 from https://www.nimh.nih.gov/about/organization/dar/stigma-and-discrimination-research-toolkit
5. Pan American Health Organization. (n.d.). *Mental health stigma reduction campaign*. Retrieved June 24, 2024 from https://www.paho.org/en/campaigns/do-your-share
6. Rössler W. (2016). The stigma of mental disorders: A millennia-long history of social exclusion and prejudices. *EMBO Rep,* 17(9), 1250-1253. https://doi.org/10.15252/embr.201643041

Provider Education and Training

Provider Relations

- Our Provider Relations team is here to support you with any educational or training needs you may have, Whether it is learning how to submit claims, navigating My Insurance Manager, or using any of our self-serving tools, your Provider Relations Consultant can provide training in the way that works best for you. It can be an on-site visit, a virtual Teams session, or any other format that fits your schedule.
- In addition to one-on-one support, we also offer annual workshops where you can connect with us in person to hear about upcoming changes, new initiatives, and other important updates for the year ahead. Plus, throughout the year, we host a variety of webinars covering topics such as provider enrollment, authorizations, and much more.
- No matter how you prefer to learn, we want to make sure you always have the resources and training you need to feel confident and supported.

Note: Review the available territory map on our website to see the Provider Relations Consultant for your area.

Contacts and Resources

Key Contacts and Resources

- Website: www.HealthyBlueSC.com
  - Quick Reference Guide
  - Provider Office Manual
  - Bulletins and News
- Healthy Blue Provider Service: 866-757-8286, 8 a.m. to 5 p.m., EST (Monday – Friday)
  - Phone number includes:
    - Case Management
    - Provider Disputes
    - Member Grievances
    - Utilization Management
- DentaQuest: 888-307-6553, 8 a.m. to 6 p.m., EST (Monday – Friday)
- 24-hour Nurseline: 800-830-1525
- Pharmacy Benefits (CarelonRX Specialty): 833-359-2169
- Modivcare: www.Modivcare.com, 8 a.m. to 5 p.m., EST (Monday – Friday)
- VSP: 800-615-1883, 8 a.m. to 5 p.m., EST (Monday – Friday), 10 a.m. to 3 p.m., EST (Saturday), 10 a.m. to 4 p.m., EST (Sunday)
- Fraud: 800-763-0703 or 888-364-3224 or FraudRes@scdhhs.gov

HEALTHY BLUE ◆ PO BOX 100317 ◆ COLUMBIA, SC ◆ 29202-3317

Provider Service: 866-757-8286 Monday – Friday from 8:30 a.m. - 5 p.m.
24-Hour Nurseline: 800-830-1525 (TTY: 711)

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