South Carolina

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

CLAIMS

CLAIMS DISCLAIMER

The information included is general and in no event should be deemed as a promise or guarantee of payment. We do not assume and hereby disclaim any liability for loss caused by errors or omissions in preparation and editing of this publication.

AGENDA

- Claim Reminders
- Claim Tips
- Resources

CLAIM REMINDERS

CLAIM REMINDERS

Medicare Advantage partners with Cotiviti

On Sept. 1, 2022, our Medicare Advantage plans partnered with Cotiviti, a market leader in payment accuracy, for periodic reviews of paid claims. Post-payment reviews include payment data validation (PDV) mining and clinical chart validation (CCV) diagnosis-related group review.

What you see:

- PDV reviews are conducted to ensure correct reimbursement and rely on paid claim data to determine accuracy
- CCV reviews are conducted to ensure proper billing and require medical records

If a claim is identified for either review, you will receive a letter identifying the claim(s) selected. Details related to the guidelines and time frames will follow.

CLAIM REMINDERS

High dollar pre-payment reviews

What is a high dollar pre-payment review (HDPR)?

- A mandate implemented by the Blue Cross Blue Shield Association (BCBSA) to review high dollar inpatient hospital claims to ensure providers are billing in accordance with services rendered.
  - Effective Oct. 1, 2018 with BlueCross BlueShield of South Carolina

What happens during the HDPR process?

- Charges on the claim are reduced based on audit findings of the claim with the highest charges.
  - The audit threshold is determined by the admission date.
- A claim line with revenue code 0249 is added to the claim.
  - Line will deny with CARC 216, RARC N183
  - Determined by the *Inpatient Non-Reimbursable Charge/Unbundling* policy
    - www.SouthCarolinaBlues.com

      Providers>Tools and Resources>Guides>Inpatient Non-Reimbursable Charge/Unbundling Policy

CLAIM REMINDERS

High dollar pre-payment reviews (cont'd)

Criteria for high dollar pre-payment reviews (HDPR).

- A HDPR takes place when the following criteria are met:
  - Inpatient institutional (acute care) claims; and
  - Claims with an allowed amount of **$100,000 or more**; and
  - Any pricing methodologies except for the following pricing models that do not incorporate individual charges due to global pricing
    - Per-diem
    - Flat-fee case rate
    - DRG rate (except those in which a portion of the claim is charge-sensitive)

What is needed for the HDPR?

- Itemized bills.
  - Submit, when requested, using the claims attachment feature in My Insurance Manager℠.
    - **If medical records are needed, a separate request will be sent.**

CLAIM REMINDERS

Itemized bills

Example of an acceptable itemized bill:

42 Rev. Co.	43 Description	44 HCPCS/Rate/HPPS Code	45 Serv. Date	46 Serv. Units	47 Total Charges
0250	Dicyclomine 10 MG		010322	1	27.00
0250	Nitroglycerin 0.4 MG		010322	1	28.73
0250	Midazolam 10 MG	J2250	010322	2	29.09
0250	Atorvastatin 40 MG		010322	2	76.93
0272	Catheter Angiographic		010322	1	226.00

Example of an unacceptable itemized bill:

42 Rev. Co.	43 Description	44 HCPCS/Rate/HPPS Code	45 Serv. Date	46 Serv. Units	47 Total Charges
0250	Pharmacy			336	7780.81
0272	Sterile supplies			8	7680.40
0278	Supply/implant		010322	2	6385.00

CLAIM REMINDERS

Laboratory services

- Avalon Healthcare Solutions manages the laboratory benefits on behalf of BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan.
- Access the current list of participating laboratories at www.SouthCarolinaBlues.com

  Providers>Policies and Authorizations>Prior Authorization>Laboratory Medical Benefits
- Before rendering lab services, review the Medical Policies pages to view the complete medical policy for specific labs to ensure the criteria is followed for coverage.

Benefits of reviewing medical policies:

- Prevents delays in claims processing
- Ensures proper and timely payment
- Reduces the need for reconsiderations

CLAIM REMINDERS

Laboratory services – medical policies

The Medical Policies pages can be accessed through one of the following:

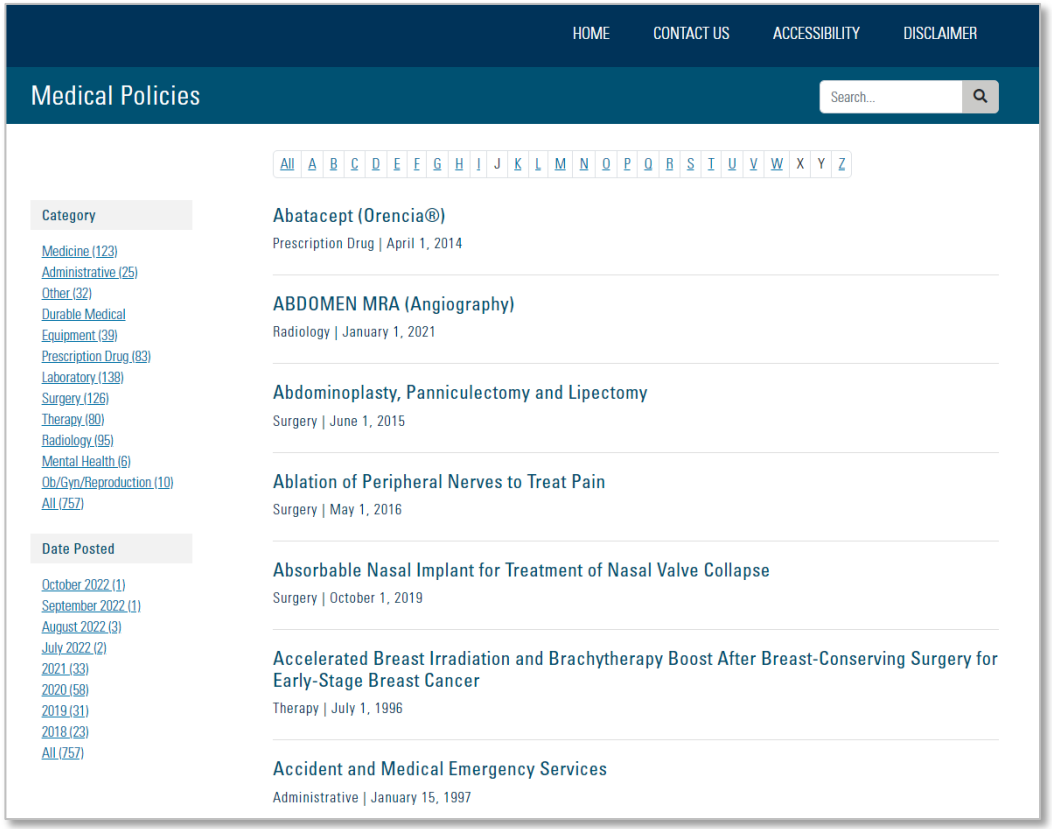
- www.SouthCarolinaBlues.com

Providers>Medical Policies>Commercial and Contracted Plan Policies

- www.BlueChoiceSC.com

Providers>Medical Policies (under Resources)>Medical Policies

Note: CPT and diagnosis codes listed on each medical policy are not a guarantee of payment but are included only as a general reference tool. They may not be all-inclusive.



CLAIM REMINDERS

Laboratory services – policy criteria

Below are the policy rule criteria used to determine coverage for laboratory services:

Policy Rule	Definition
Experimental and investigational	Procedure is not covered under the member's benefit due to exclusion
Demographic limitations	Limitations based on the member's age/sex
Excessive procedure units	Total units within and across claims for a single date of service more than necessary
Excessive units per period of time	Maximum allowable units within a defined period of time has been exceeded
Insufficient time between procedures	Minimum time required before a second procedure is warranted
Rendering provider limitations	Providers/procedures not permitted in combination
Diagnosis does not support test requested	Procedure was not appropriate for the clinical situation
Mutually exclusive codes	The procedure is not valid with other procedures on the same date of service

Examples

Laboratory Test	Example	Rejection Applied
Vitamin D	Testing rendered two weeks after initiation of Vitamin D therapy	Insufficient time between procedures
Thyroid Disease	Testing of reverse T3, T3 uptake	Experimental and investigational
Testosterone	Testing saliva for testosterone	Experimental and investigational

CLAIM REMINDERS

Provider reconsiderations

What is a provider reconsideration?

- A request to investigate the outcome of a finalized claim.

What are the guidelines for a provider reconsideration?

Reasons that would require a reconsideration…	[1] Reasons that would not require a reconsideration…
Medical necessity determination	Membership, eligibility or benefit issues
Lack of authorization for non-emergent services when the member does not present themselves as a BlueCross BlueShield of South Carolina member	Lack of authorization for non-emergent services when the member presents themselves as a BlueCross BlueShield of South Carolina member

[1]For reasons listed in this column, contact the appropriate Provider Services department using Ask Provider Services, STATchat℠, or call the phone number on the back of the member's ID card.

CLAIM REMINDERS

Provider reconsiderations – requirements

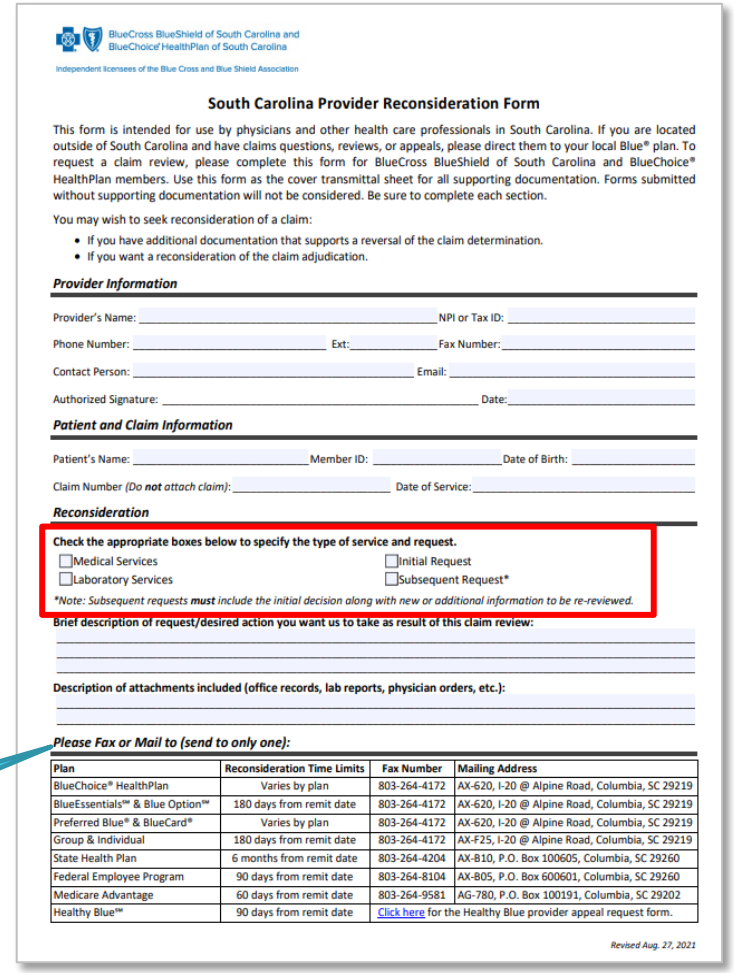
Provider Reconsideration Form

- www.SouthCarolinaBlues.com
  - *Providers>Claims & Payment>Appeals & Reconsiderations*
- www.BlueChoiceSC.com
  - *Providers>Find a Form>Provider Reconsideration Form*

Supporting Documentation

- Supporting document must be included, such as:
  - History and physical records
  - Operative reports
  - Office notes
  - Progressive notes
- **Reconsiderations cannot be reviewed without support.**

Be mindful of the filing guidelines.



BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

South Carolina Provider Reconsideration Form

This form is intended for use by physicians and other health care professionals in South Carolina. If you are located outside of South Carolina and have claims questions, reviews, or appeals, please direct them to your local Blue® plan. To request a claim review, please complete this form for BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan members. Use this form as the cover transmittal sheet for all supporting documentation. Forms submitted without supporting documentation will not be considered. Be sure to complete each section.

You may wish to seek reconsideration of a claim:

- If you have additional documentation that supports a reversal of the claim determination.
- If you want a reconsideration of the claim adjudication.

Provider Information

Provider's Name: _____ NPI or Tax ID: _____

Phone Number: _____ Ext: _____ Fax Number: _____

Contact Person: _____ Email: _____

Authorized Signature: _____ Date: _____

Patient and Claim Information

Patient's Name: _____ Member ID: _____ Date of Birth: _____

Claim Number *(Do **not** attach claim)*: _____ Date of Service: _____

Reconsideration

Check the appropriate boxes below to specify the type of service and request.

☐ Medical Services ☐ Initial Request

☐ Laboratory Services ☐ Subsequent Request*

Note: Subsequent requests **must include the initial decision along with new or additional information to be re-reviewed.*

Brief description of request/desired action you want us to take as result of this claim review:

Description of attachments included (office records, lab reports, physician orders, etc.):

Please Fax or Mail to (send to only one):

Plan	Reconsideration Time Limits	Fax Number	Mailing Address
BlueChoice® HealthPlan	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
BlueEssentials™ & Blue Option™	180 days from remit date	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
Preferred Blue® & BlueCard®	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
Group & Individual	180 days from remit date	803-264-4172	AX-F25, I-20 @ Alpine Road, Columbia, SC 29219
State Health Plan	6 months from remit date	803-264-4204	AX-B10, P.O. Box 100605, Columbia, SC 29260
Federal Employee Program	90 days from remit date	803-264-8104	AX-B05, P.O. Box 600601, Columbia, SC 29260
Medicare Advantage	60 days from remit date	803-264-9581	AG-780, P.O. Box 100191, Columbia, SC 29202
Healthy Blue℠	90 days from remit date	Click here for the Healthy Blue provider appeal request form.	

Revised Aug. 27, 2021

CLAIM REMINDERS

Provider reconsiderations vs. corrected claims

Knowing when to submit a provider reconsideration versus a corrected claim is important.

Examples of when a provider reconsideration can be submitted.

Provider reconsideration
A claim is rejected because the medical necessity could not be determined
A claim is rejected for lack of authorization, but the member was comatose when they arrived at the hospital

Examples of when a corrected claim should be submitted.

Corrected claim
An anesthesia claim is submitted with the incorrect modifier and rejects as a duplicate
A provider only performs the Cesarean delivery, but submits their claim with the procedure 59515 (which includes postpartum care), causing the claim to process globally

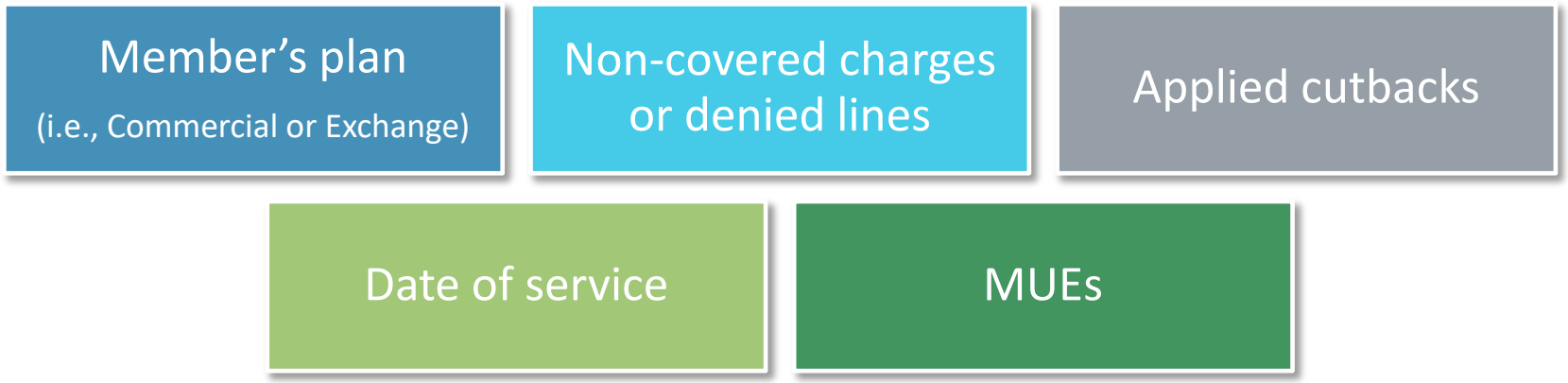
CLAIM REMINDERS

Pricing inquiries

What is a pricing inquiry?

- An investigation of the reimbursement applied to a claim.

Before submitting pricing inquiries, verify the following:



Note: If using a third-party vendor, be sure to relay this information to them.

CLAIM REMINDERS

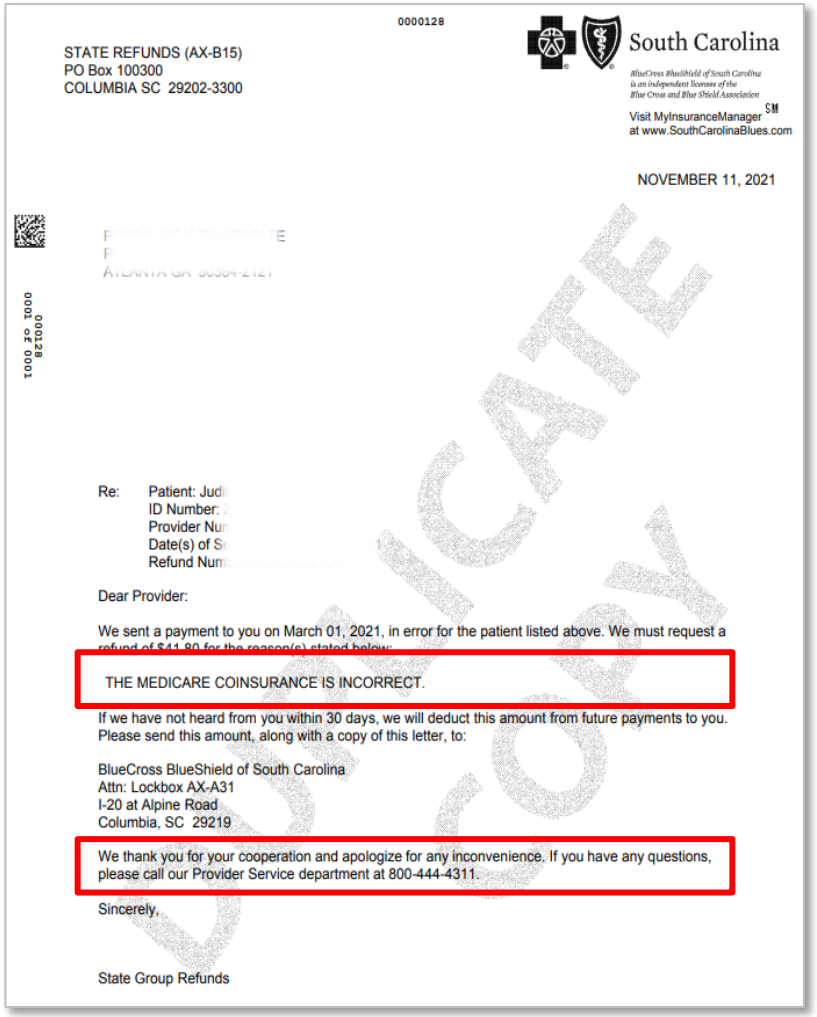
Refunds

For assistance with refunds:

- Access My Insurance Manager℠
- Contact the number on the back of the member's ID card.

If you do not have the refund letter:

- Call Provider Services: 800-868-2510, opt. 4
  - Used for the following lines of business:
    - BlueCard®
    - BlueEssentials℠
    - Major Group
    - National Alliance
    - Small Group & Individual



0000128

STATE REFUNDS (AX-B15)
PO Box 100300
COLUMBIA SC 29202-3300

South Carolina
BlueCross BlueShield of South Carolina is an Independent Licensee of the Blue Cross and Blue Shield Association

Visit MyInsuranceManager℠ at www.SouthCarolinaBlues.com

NOVEMBER 11, 2021

0001 of 0001 0000128

Re: Patient: Jud
ID Number:
Provider Nu
Date(s) of S
Refund Num

Dear Provider:

We sent a payment to you on March 01, 2021, in error for the patient listed above. We must request a refund of $41.80 for the reason(s) stated below:

THE MEDICARE COINSURANCE IS INCORRECT.

If we have not heard from you within 30 days, we will deduct this amount from future payments to you. Please send this amount, along with a copy of this letter, to:

BlueCross BlueShield of South Carolina
Attn: Lockbox AX-A31
I-20 at Alpine Road
Columbia, SC 29219

We thank you for your cooperation and apologize for any inconvenience. If you have any questions, please call our Provider Service department at 800-444-4311.

Sincerely,

State Group Refunds

DUPLICATE COPY

CLAIM REMINDERS

Network participating providers

Network participating providers should always use or refer members to other network participating providers, when necessary, including laboratories.

By using or referring other network participating providers:

- Members will not have to bear the burden of higher out-of-pocket costs
- Members will not be subject to balance billing

CLAIM REMINDERS

Claims submission

Claims can be submitted using the following:

- Electronically
  - Preferred method
  - See the payer IDs
- My Insurance Manager℠ (MIM)
- Mail (hard copy)
  - Use the address located on the back of the member's ID card

For more information, visit www.SouthCarolinaBlues.com:

Providers>Claims & Payments>Claims Submission

Medical Plans	
State Health Plan	00400
BlueCross BlueShield of South Carolina	00401
Federal Employee Plan (FEP)	00402
Healthy Blue℠	00403
Planned Administrators, Inc. (PAI)	00886
BlueChoice® HealthPlan	00922
Medicare Advantage	00C63

Dental Plans	
BlueCross BlueShield of South Carolina	38520

CLAIM REMINDERS

Corrected claims

- Corrected claims can be submitted using one of the following avenues:
  - Electronically (the preferred method)
    - Enter frequency code 7 (which indicates an adjustment) in Box 22 of the CMS-1500
    - Enter the original claim number in Box 22 of the CMS-1500
    - Include a brief description for the reason of the adjustment in Box 19 of the CMS-1500
  - My Insurance Manager℠ (MIM)
    - Select Replacement of Prior Claim on the Claim Information page
  - Mail (hard copy)
    - Ensure “Corrected Claim” is labeled on the claim.
- For all avenues, be sure to include **all lines** from the original claim along with the correction(s) that should be made.
- Guidance on submitting corrected claims can be located on www.SouthCarolinaBlues.com

Providers>News and Events>News Archive>2021 News>Reminder: Corrected Claims

CLAIM TIPS

CLAIM TIPS

Claims that require questionnaire responses

- Accident or subrogation
  - Generated based on trauma related diagnoses on a claim
  - Allow members at least 60 days to respond and for the review to be completed
    - If the member does not respond within 60 days, medical records can be submitted
      - Medical records are not guaranteed to overturn the rejection
- Other health insurance (OHI)
  - Generated based on the member's age, if they have more that one policy on file, etc.
  - Must be completed by the member or the member can contact customer service to verify/update

Encourage members to return the questionnaire as soon as possible to avoid processing delays

Incorporate the forms in the onboarding paperwork

Only submit the documentation if requested.

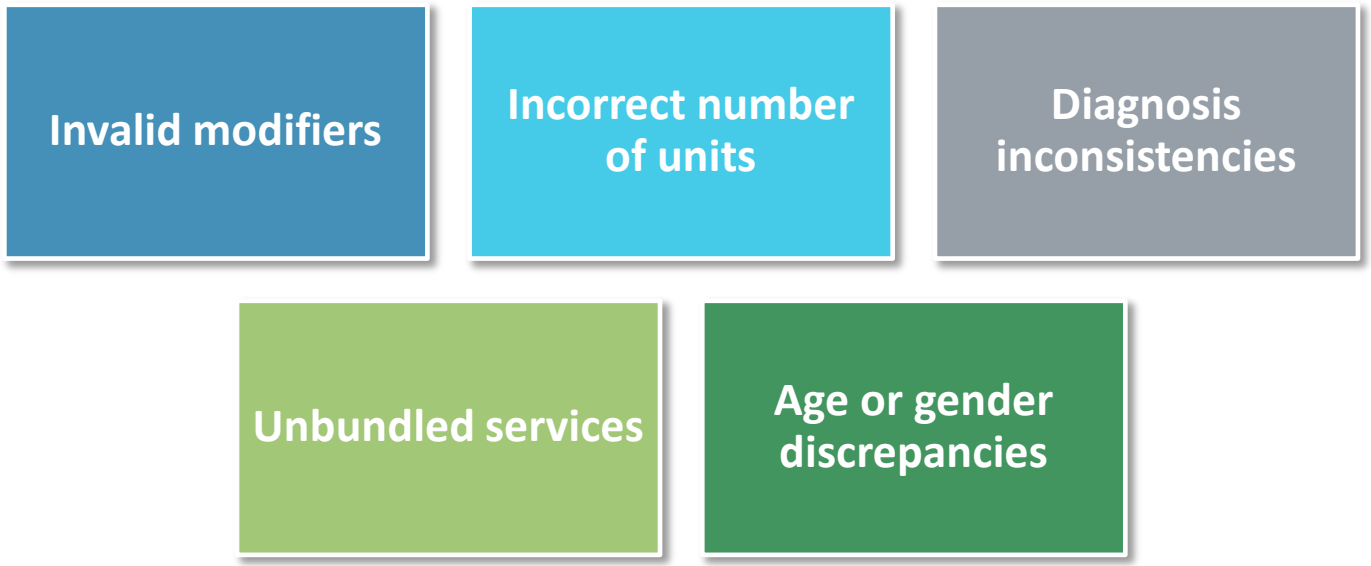
Note: Both forms are on www.SouthCarolinaBlues.com.

Providers>Forms>Other Forms

CLAIM TIPS

Correct coding

- Accurate coding and reporting of services on medical claims is critical in assuring proper payment to providers.
- Common coding issues include:



RESOURCES

RESOURCES

Voice response unit (VRU)

If we processed and paid a claim or applied patient liability, the VRU will provide:

- Processed date
- Remittance date
- Check number
- Amount paid
- Amount applied to the patient's liability (copay, deductible or coinsurance)

If we processed and denied a claim, the VRU will provide:

- Denial reason
- Remittance date

Note: If a claim is processed to the member, please contact them for the details. Submitting a HIPAA transaction (276/277) will advise if the claim was processed to the member.

RESOURCES

My Insurance Manager℠

My Insurance Manager (MIM) is the quickest way to obtain claims information. With MIM, providers can:

- Submit claims
- Check claims status
- View refund letters
- Get assistance with claims
  - Ask Provider Services
  - STATchat℠

Additional information included in MIM:

- Eligibility and benefits
- Prior authorizations
- Provider updates

RESOURCES

Ask Provider Services (Web inquiries)

- Ask Provider Services is a feature inside My Insurance Manager℠ that allows providers to submit secured web inquiries for assistance with claims.
- To receive the most effective and accurate responses, ask specific, probing questions.
  - This feature should not be used for general claim status.

Examples of appropriate questions to ask…	Examples of inappropriate questions to ask…
Why was line one of the claim denied as noncovered?	What is the status of the claim?
Why were services applied to the member's deductible?	Have medical records been received?
Has the member returned the coordination of benefits questionnaire?	Has the claim been processed?

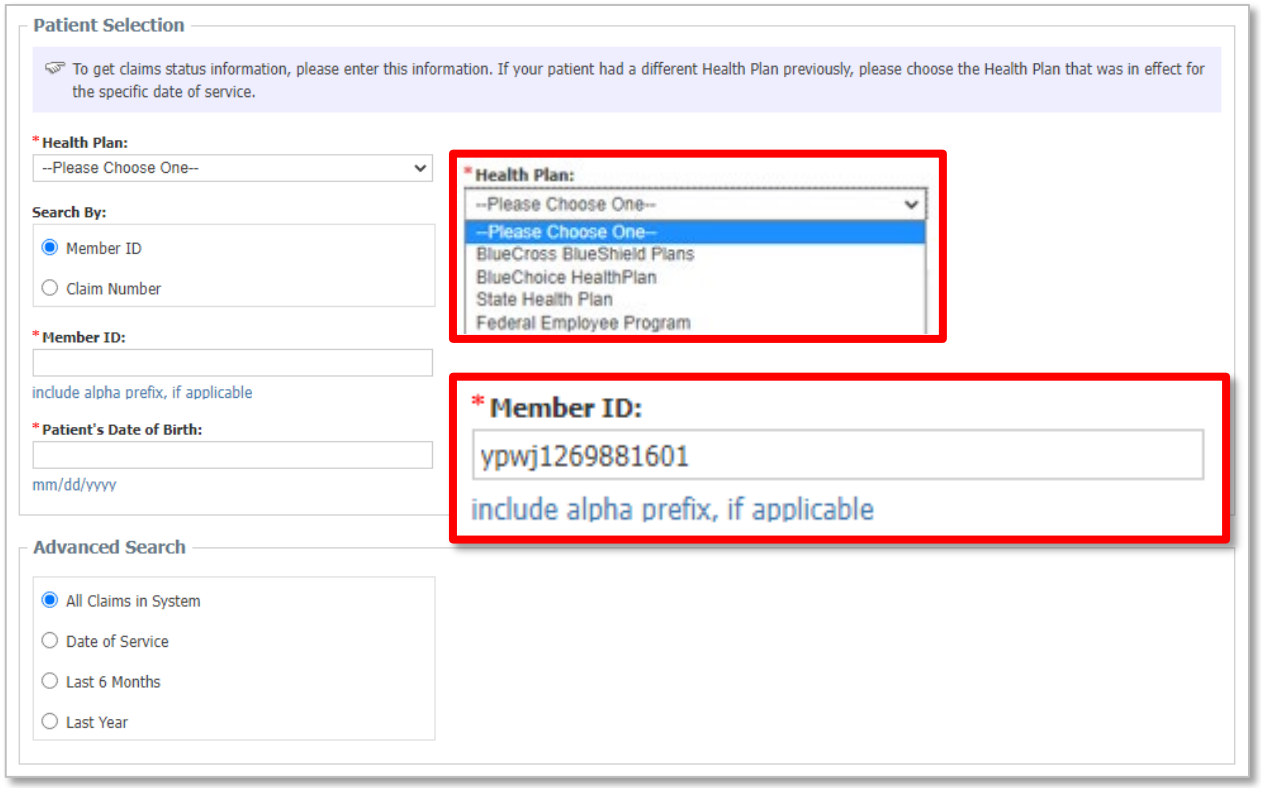
RESOURCES

Ask Provider Services – submitting web inquiries

Searching by Member ID

Be sure to:

- Select the appropriate Health Plan
- Enter the **FULL** Member ID, including the prefix and any additional letters
- Enter the date of birth
- Select one of the advanced options



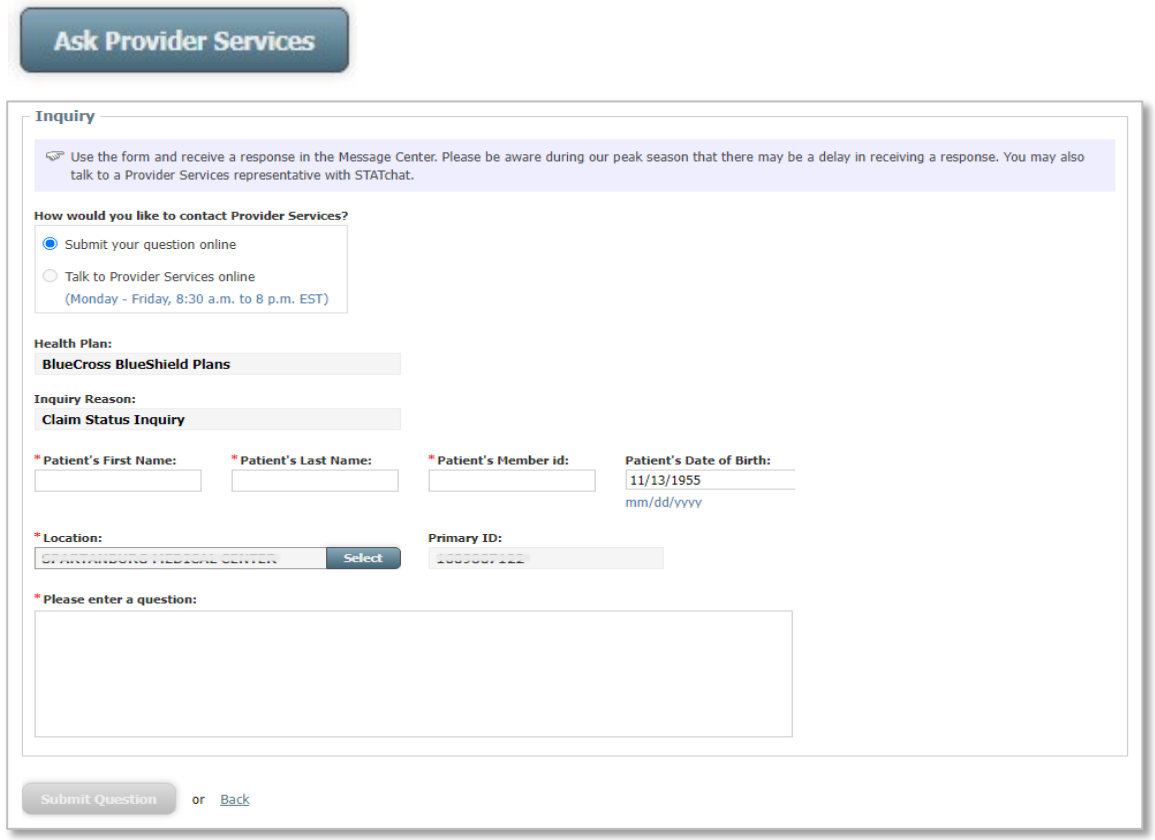
RESOURCES

Ask Provider Services – submitting web inquiries

Searching by Member ID (cont'd)

Be sure to:

- Enter the patient's first and last name
- Enter the **FULL** Member ID, including the prefix and any additional letters
- The date of birth and location will auto-populate from the selected claim
- Enter your question (be specific as possible)



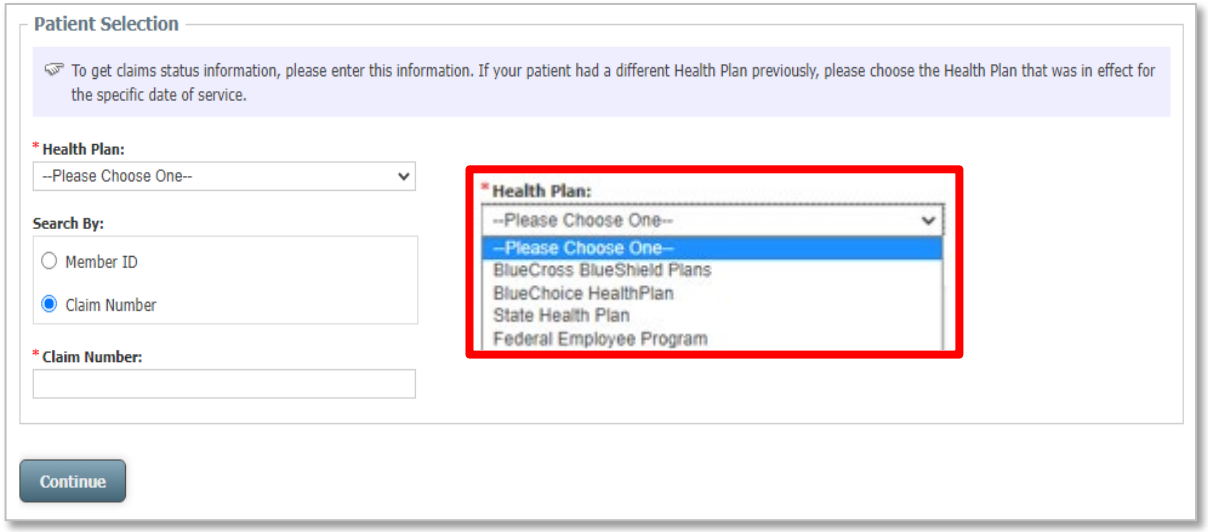
RESOURCES

Ask Provider Services – submitting web inquiries

Searching by claim number

Be sure to:

- Select the appropriate Health Plan
- Enter the claim number



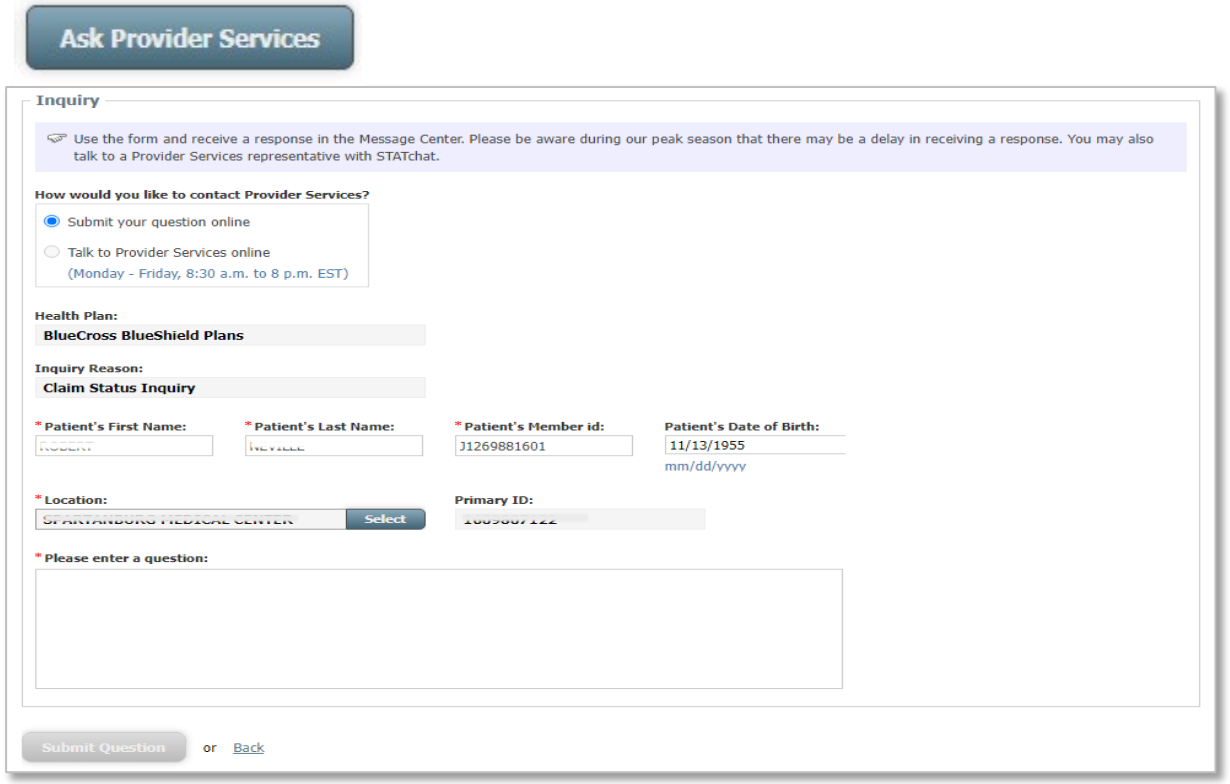
RESOURCES

Ask Provider Services – submitting web inquiries

Searching by claim number (cont'd)

Be sure to:

- The patient's name, ID number, date of birth and location will auto-populate from the entered claim
- Enter your question (be specific as possible)

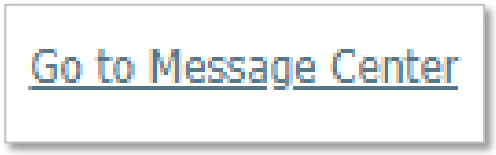


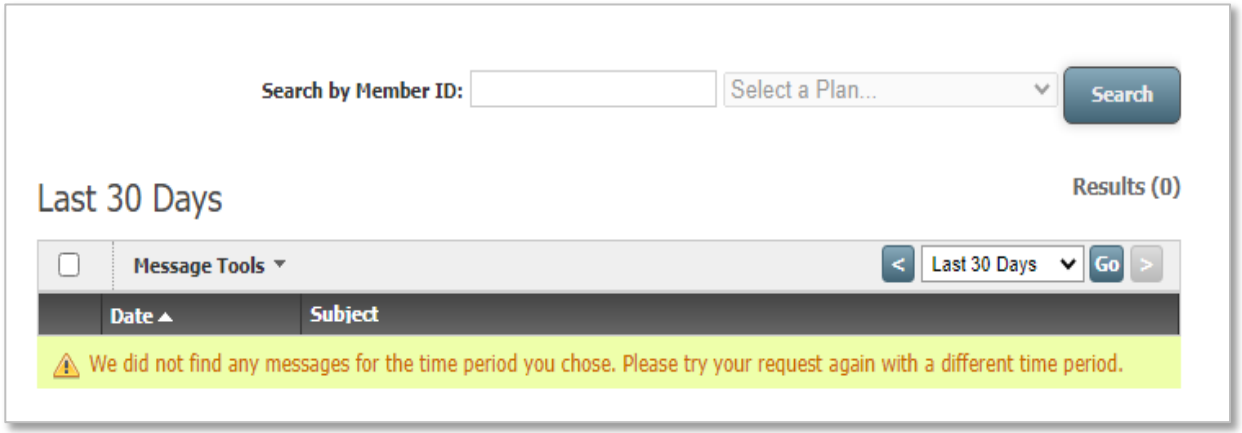
RESOURCES

Ask Provider Services – viewing web inquiry responses

Be sure to:

- Select Go to Message Center
- To narrow the results, you can:
  - Enter the ID number and select the Health Plan
  - Select specific months





Note: If you submit an inquiry in one month and do not see a response, search by the member's ID number. The response may be listed under a different month.