2024 Healthy Blue Annual Provider Training

Frequently Asked Questions

If a member does not notify the provider of eligibility with Healthy Blue until after the timely filing period has passed, can the provider bill the patient?

No, providers cannot balance bill the member.

Can H0002 and H0004 be billed together?

Yes, these two codes can be billed together on the same claim. The H0002 is for the screening incentive, while the H0004 is for the brief intervention incentive.

Are FQHCs eligible for the provider incentives?

Yes, if the provider is a primary care physician, or an OB/GYN for the CenteringPregnancy incentive.

Do members get incentives?

Yes, there are incentives for members. Some include well-child visits, prenatal care visits, diabetic eye exams and much more. The member can visit www.HealthyBlueSC.com for a full listing. Note that eligibility and limitations may apply.

What do you do when a patient is non-compliant and will not update their coordination of benefits?

If you believe the patient has other health insurance, encourage them to make the necessary updates with the State and with Healthy Blue.

Why did you switch from Availity?

Availity is a platform used by Elevance. Now that Healthy Blue is under the BlueChoice® HealthPlan, providers must use My Insurance Manager℠. Note that for claims with dates of service on or before Dec. 31, 2023, you can use Availity to access the claims data.

How can providers remove patients from their member roster?

If the patient is not one of your members, encourage them to complete the PCP Selection Form on www.HealthyBlueSC.com.

Is there an authorization grace period?

No, there is no grace period for prior authorizations. Providers must get prior authorizations before rendering services.

Will Cohere Health manage physical, speech and ABA therapy prior authorizations?

Soon, Cohere Health will be the new platform used to get prior authorizations. However, all clinical decisions will still be made by Healthy Blue.

Is a signed contract required to bill services under the school-based behavioral health program?

Yes, providers must be credentialed with Healthy Blue and required to have a subcontract with the local education agency.

If a provider sees a patient in their private practice and needs to see them at a school, how should the claim be filed?

Providers should always use the appropriate place of service when submitting claims. If services were rendered in the school, the place of service on the claim should be the school.

For provider enrollment, how long do case comments get reviewed?

If the case is not denied or canceled (both indicate the case is closed), the case comments are reviewed.

How can a provider remove old or duplicate cases from their view in My Provider Enrollment Portal?

Currently, providers cannot remove old or duplicate cases.

How long does it take a newly enrolled provider to show up in My Insurance Manager?

For a new group practice, once the congratulatory email or notification is received, the group practice must create a new account in My Insurance Manager.

For a new individual provider joining an established group practice, once the congratulatory email or notification is received, the provider administrator can add the provider to their affiliations in My Insurance Manager.

What's the difference between the provider's network effective date and affiliation date? Which date is used to process claims?

The provider's network effective date is based on the credentialing committee's approval date and cannot be backdated. This date can differ from the provider's start date with the group practice.

The provider's affiliation date is typically their start date with the group practice.

For Healthy Blue, claims are processed based on the provider's network effective date.

Is the home health limit of 50 for PT, ST and OT combined or separate?

The visits are combined; 50 per benefit year.

Do the Healthy Blue policy numbers still begin with ZCD?

Yes, member's still have the prefix of ZCD for their identification numbers.

What does it mean to be non-credentialed, but on file?

Non-credentialed means the provider is not part of any networks. However, they can be on file to submit claims.

On the authorization to bill, what is the difference between the date of request and the effective date?

The date of request is the date the form was completed. The effective date is the date the provider will be on file with Healthy Blue for payment (which is typically the provider's start date with the group).

On the enrollment application, does "do you accept Medicaid" refer to current status or future?

This question is asking if the provider currently accepts Medicaid.