2024 HEALTHY BLUE℠
Annual Provider Training

Back Under the Umbrella

Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

Disclaimer

The information included in this presentation 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.

Topics

- Rights and Responsibilities
- Contacts and Resources
- Benefit Partners
- Member Benefits
- Prior Authorization
- Claims
- Provider Incentives
- Behavioral Health
- Provider Enrollment
- Pharmacy
- Quality
- Community Outreach

Rights and Responsibilities

Provider Rights and Responsibilities

Physicians and other health care providers have rights and responsibilities as health care providers.

Provider **rights** include:

- Receiving information on grievances and disputes.
- Having access to policies and procedures covering authorization of services.
- Being notified of any decision to deny a service authorization request or to authorize a services in an amount, duration or scope less than requested.
- And more.

Provider **responsibilities** include:

- Documenting health care screenings, immunizations, procedures, etc.
- Scheduling preventive care appointments for all members under age 21.
- Referring members to appropriate dentists, optometrists, case management, etc.
- And more.

Note: Refer to the Provider Office Manual for a full list.

Member Rights and Responsibilities

Physicians and other health care providers should be aware of the member's rights and responsibilities as health care providers.

Member **rights** include:

- Being treated with respect and regard for their dignity and privacy.
- Taking part in decisions about their health.
- Refusing care or treatment.
- And more.

Member **responsibilities** include:

- Showing their identification cards at each visit.
- Keeping and being on time for doctor visits.
- Treating their primary care physician and staff with respect.
- And more.

Note: Refer to the Provider Office Manual for a full list.

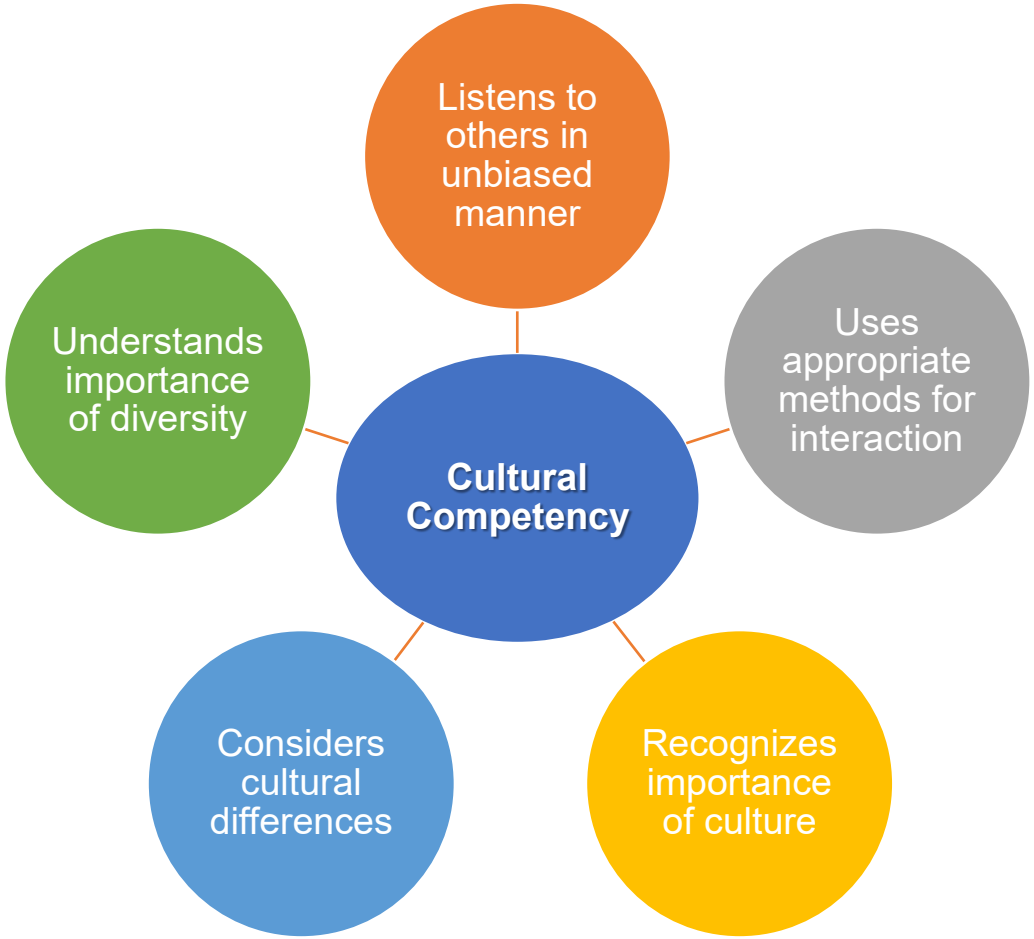
Cultural Competency

Being culturally competent plays an integral role in the quality of care you provide.

- Cultural competency is a set of congruent behaviors, attitudes, and policies that enable effective work in cross-cultural situations.
- Cultural awareness is the ability to recognize the cultural factors, norms, values, communication patterns, socioeconomic status and world views that shape personal and professional behavior.

To learn more, visit www.HealthyBlueSC.com and under the Provider section, select Quality, then Improving Your Patient's Experience.

Skills for Cultural Competency



Fraud, Waste and Abuse

Provider's Role

Comply with statutory, regulatory and Medicaid managed care requirements in South Carolina

Report any law violations and follow the code of conduct for ethical rules of behavior

How to Report

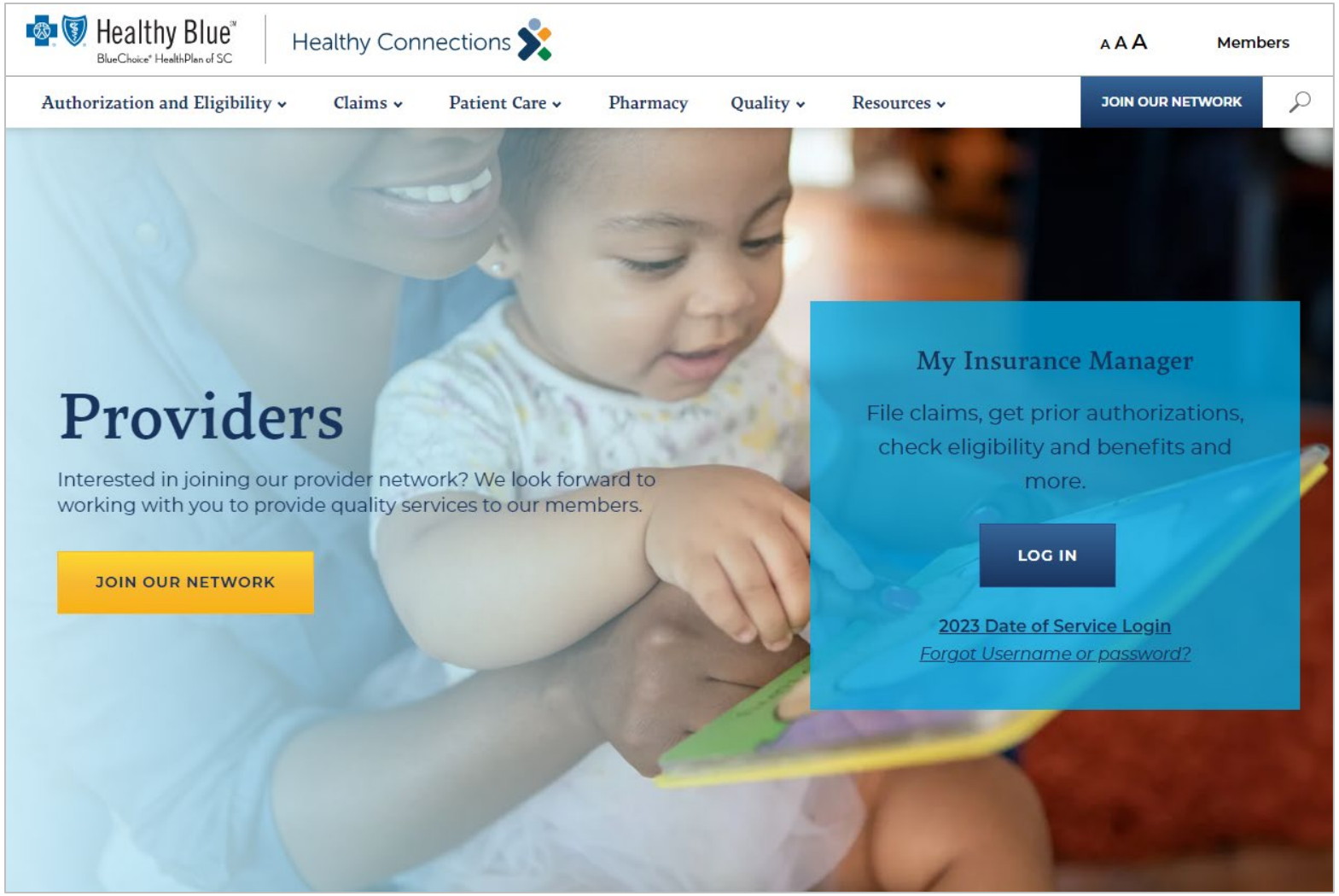
Call Healthy Blue at 800-763-0703

Call the South Carolina Department of Health and Human Services at 888-364-3224 or email fraudres@scdhhs.gov

Contacts and Resources

Visit www.HealthyBlueSC.com and access:

- Authorizations and Eligibility.
- Claims.
- Patient Care.
- Pharmacy.
- Quality.
- Resources.
- And much more.



Quick Reference Guide*

Providers>Resources>User Manual, Guides and Forms

24/7 Nurse Line

Phone: 866-577-9710

Provider Service

Phone: 866-757-8286

Hours: Monday – Friday, 8:30 a.m. to 5 p.m. EST

Case Management

Phone: 866-757-8286

Hours: Monday – Friday, 8:30 a.m. to 5 p.m. EST

Refunds and Overpayments

Phone: 866-757-8286

Hours: Monday – Friday, 8:30 a.m. to 5 p.m. EST

Utilization Management (UM) Department

Phone: 866-757-8286

Fax: 803-870-6500

Hours: Monday – Friday, 8:30 a.m. to 5 p.m. EST

Note: The fax number is used for prior authorizations and inpatient hospital continued stay reviews.

The Quick Reference Guide contains valuable information such as contacts for eligibility, benefits and claims.

CarelonRx – Pharmacy

Retail

Phone: 844-410-6890

Fax: 844-512-9005

Hours: Monday – Friday, 8:30 a.m. to 8 p.m. EST

Saturday, 10 a.m. to 2 p.m. EST

Specialty Pharmacy

Phone: 833-262-1726

Hours: 24/7

Home Delivery and Mail Order

Phone: 833-396-0309

Hours: 24/7

Pharmacy Help Desk

Phone: 833-253-4711

Hours: 24/7

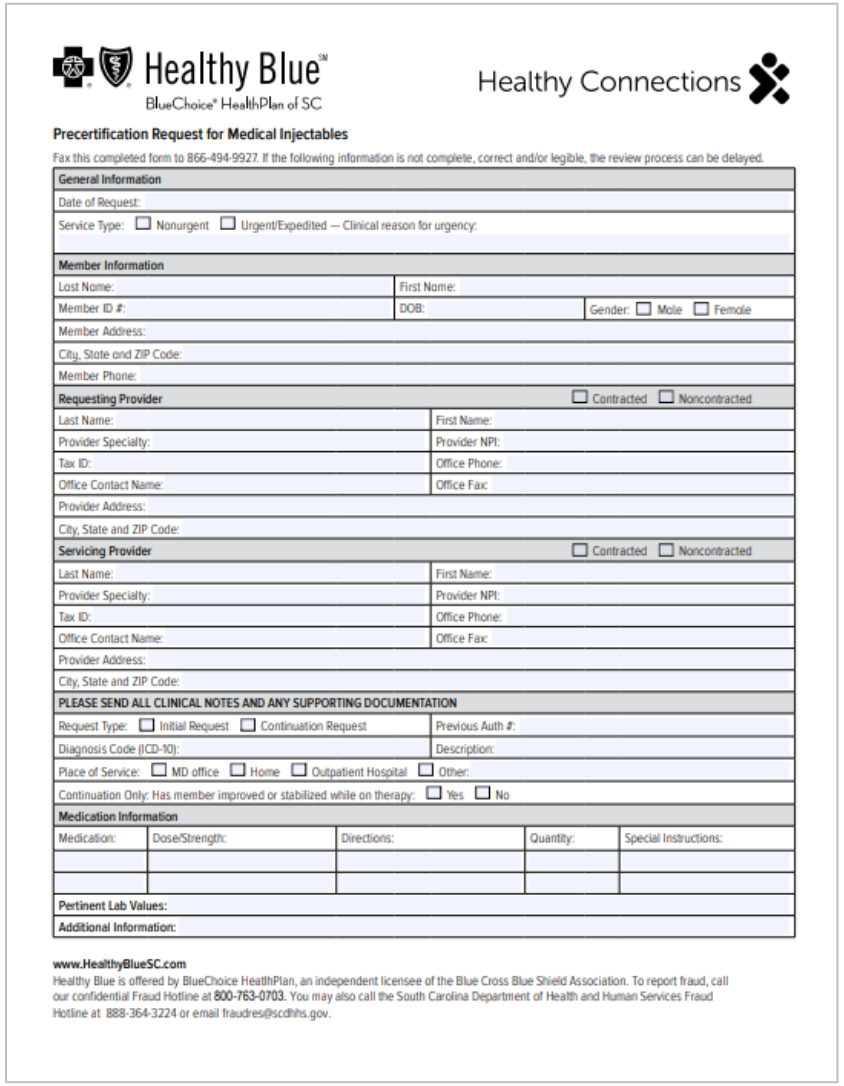
CarelonRx Inc. is an independent company providing pharmacy benefit management services on behalf of Healthy Blue.

CVS/Novologix

CVS/Novologix provides medical injectable benefit management services.

Request an authorization by:

- Phone: 844-345-2803
  - Hours: Monday – Friday, 9 a.m. to 7 p.m. EST
- Fax: 866-494-9927
  - Complete the Precertification Request for Medical Injectables form.
  - Providers>Pharmacy
    - Review the **medical specialty drug** list to determine which drugs require authorization.



Healthy Blue
BlueChoice® HealthPlan of SC

Healthy Connections

Precertification Request for Medical Injectables

Fax this completed form to 866-494-9927. If the following information is not complete, correct and/or legible, the review process can be delayed.

General Information		
Date of Request:		
Service Type: ☐ Nonurgent ☐ Urgent/Expedited – Clinical reason for urgency:		
Member Information		
Last Name:	First Name:	
Member ID #:	DOB:	Gender: ☐ Male ☐ Female
Member Address:		
City, State and ZIP Code:		
Member Phone:		
Requesting Provider		☐ Contracted ☐ Noncontracted
Last Name:	First Name:	
Provider Specialty:	Provider NPI:	
Tax ID:	Office Phone:	
Office Contact Name:	Office Fax:	
Provider Address:		
City, State and ZIP Code:		
Servicing Provider		☐ Contracted ☐ Noncontracted
Last Name:	First Name:	
Provider Specialty:	Provider NPI:	
Tax ID:	Office Phone:	
Office Contact Name:	Office Fax:	
Provider Address:		
City, State and ZIP Code:		
PLEASE SEND ALL CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION		
Request Type: ☐ Initial Request ☐ Continuation Request	Previous Auth #:	
Diagnosis Code (ICD-10):	Description:	
Place of Service: ☐ MD office ☐ Home ☐ Outpatient Hospital ☐ Other:		
Continuation Only: Has member improved or stabilized while on therapy: ☐ Yes ☐ No		

Medication Information				
Medication:	Dose/Strength:	Directions:	Quantity:	Special Instructions:
Pertinent Lab Values:				
Additional Information:				

www.HealthyBlueSC.com
Healthy Blue is offered by BlueChoice HealthPlan, an independent licensee of the Blue Cross Blue Shield Association. To report fraud, call our confidential Fraud Hotline at 800-763-0703. You may also call the South Carolina Department of Health and Human Services Fraud Hotline at 888-364-3224 or email fraudres@scdhhs.gov.

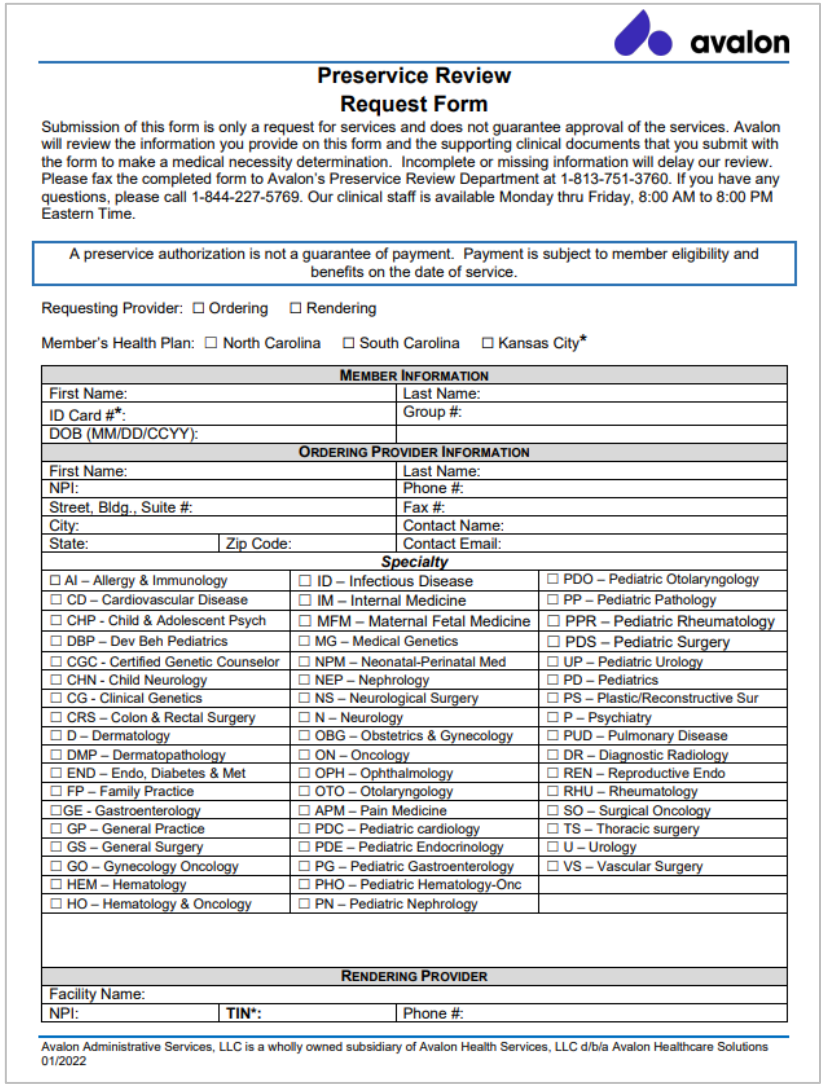
CVS/Novologix is an independent company providing medical injectable benefit management services on behalf of Healthy Blue.

Avalon Healthcare Solutions

Avalon provides laboratory benefit management services.

Request an authorization by:

- PAS Portal
  - www.avalonhcs.com
- Phone: 844-227-5769
  - Hours: Monday – Friday, 8 a.m. to 8 p.m. EST
- Fax: 813-751-3760
  - Complete the Preservice Review Request form.
  - Providers>Authorizations and Eligibility>Prior Authorization



avalon

Preservice Review Request Form

Submission of this form is only a request for services and does not guarantee approval of the services. Avalon will review the information you provide on this form and the supporting clinical documents that you submit with the form to make a medical necessity determination. Incomplete or missing information will delay our review. Please fax the completed form to Avalon's Preservice Review Department at 1-813-751-3760. If you have any questions, please call 1-844-227-5769. Our clinical staff is available Monday thru Friday, 8:00 AM to 8:00 PM Eastern Time.

A preservice authorization is not a guarantee of payment. Payment is subject to member eligibility and benefits on the date of service.

Requesting Provider: ☐ Ordering ☐ Rendering

Member's Health Plan: ☐ North Carolina ☐ South Carolina ☐ Kansas City*

MEMBER INFORMATION		
First Name:		Last Name:
ID Card #*:		Group #:
DOB (MM/DD/CCYY):		
ORDERING PROVIDER INFORMATION		
First Name:		Last Name:
NPI:		Phone #:
Street, Bldg., Suite #:		Fax #:
City:		Contact Name:
State:	Zip Code:	Contact Email:

Specialty

☐ AI – Allergy & Immunology	☐ ID – Infectious Disease	☐ PDO – Pediatric Otolaryngology
☐ CD – Cardiovascular Disease	☐ IM – Internal Medicine	☐ PP – Pediatric Pathology
☐ CHP - Child & Adolescent Psych	☐ MFM – Maternal Fetal Medicine	☐ PPR – Pediatric Rheumatology
☐ DBP – Dev Beh Pediatrics	☐ MG – Medical Genetics	☐ PDS – Pediatric Surgery
☐ CGC - Certified Genetic Counselor	☐ NPM – Neonatal-Perinatal Med	☐ UP – Pediatric Urology
☐ CHN - Child Neurology	☐ NEP – Nephrology	☐ PD – Pediatrics
☐ CG - Clinical Genetics	☐ NS – Neurological Surgery	☐ PS – Plastic/Reconstructive Sur
☐ CRS – Colon & Rectal Surgery	☐ N – Neurology	☐ P – Psychiatry
☐ D – Dermatology	☐ OBG – Obstetrics & Gynecology	☐ PUD – Pulmonary Disease
☐ DMP – Dermatopathology	☐ ON – Oncology	☐ DR – Diagnostic Radiology
☐ END – Endo, Diabetes & Met	☐ OPH – Ophthalmology	☐ REN – Reproductive Endo
☐ FP – Family Practice	☐ OTO – Otolaryngology	☐ RHU – Rheumatology
☐GE - Gastroenterology	☐ APM – Pain Medicine	☐ SO – Surgical Oncology
☐ GP – General Practice	☐ PDC – Pediatric cardiology	☐ TS – Thoracic surgery
☐ GS – General Surgery	☐ PDE – Pediatric Endocrinology	☐ U – Urology
☐ GO – Gynecology Oncology	☐ PG – Pediatric Gastroenterology	☐ VS – Vascular Surgery
☐ HEM – Hematology	☐ PHO – Pediatric Hematology-Onc	
☐ HO – Hematology & Oncology	☐ PN – Pediatric Nephrology	

RENDERING PROVIDER		
Facility Name:		
NPI:	**TIN*:**	Phone #:

Avalon Administrative Services, LLC is a wholly owned subsidiary of Avalon Health Services, LLC d/b/a Avalon Healthcare Solutions
01/2022

Avalon is an independent company providing laboratory benefit management services on behalf of Healthy Blue.

Evolent

- Evolent provides radiology benefit management services.
- Improves outcomes for members with health conditions.
- Access clinical guidelines and experts.

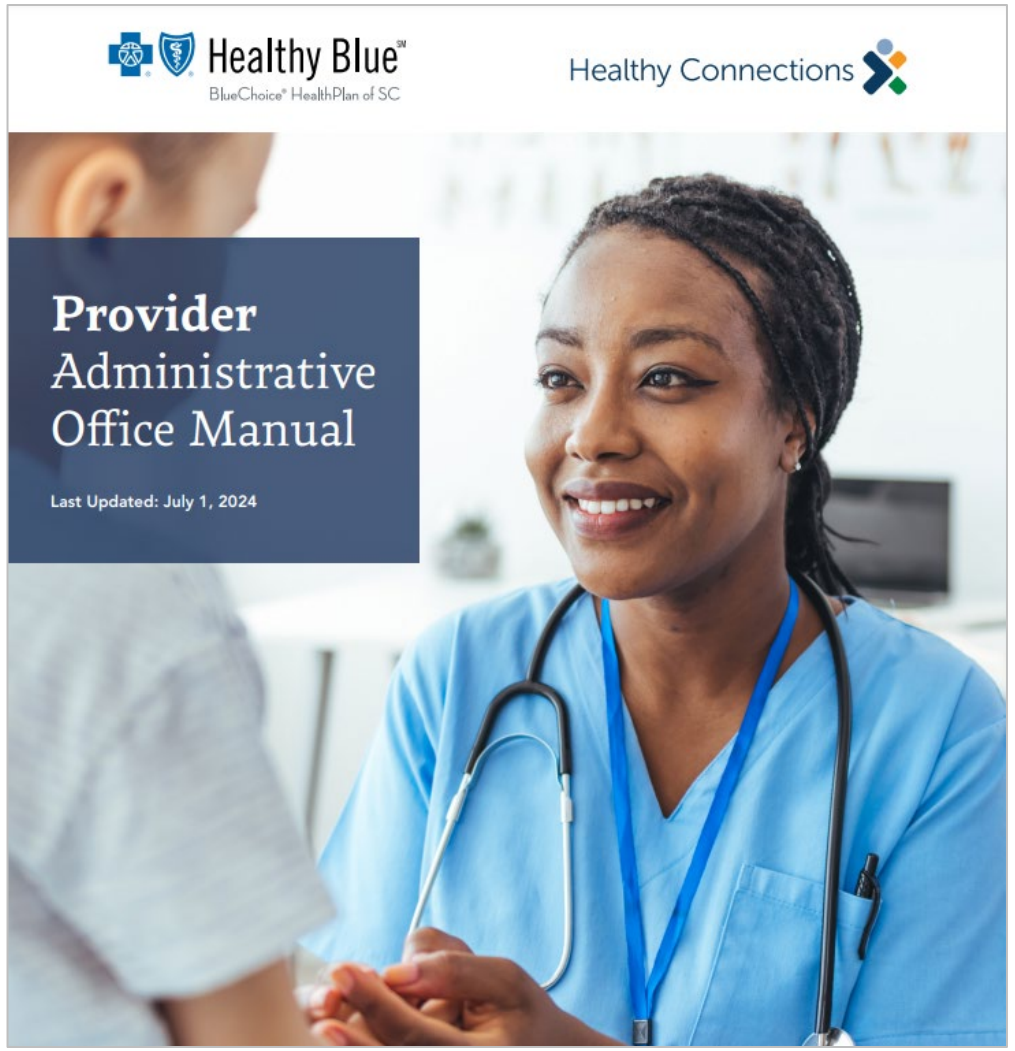
Request an authorization:

- Online
  - www.RadMD.com
- Phone: 855-569-6749

Evolent is an independent company providing radiology benefit management services on behalf of Healthy Blue.

Provider Office Manual

- Administrative Information
- Quality Improvements
- Utilization Management
- Claims Information



Providers>Resources>User Manual, Guides and Forms

Note: The manual is updated regularly.

BlueBlast

Important health updates and events

Healthy Connections updates

Notifications and reminders

Billing and claims information

Providers>Resources>Provider News

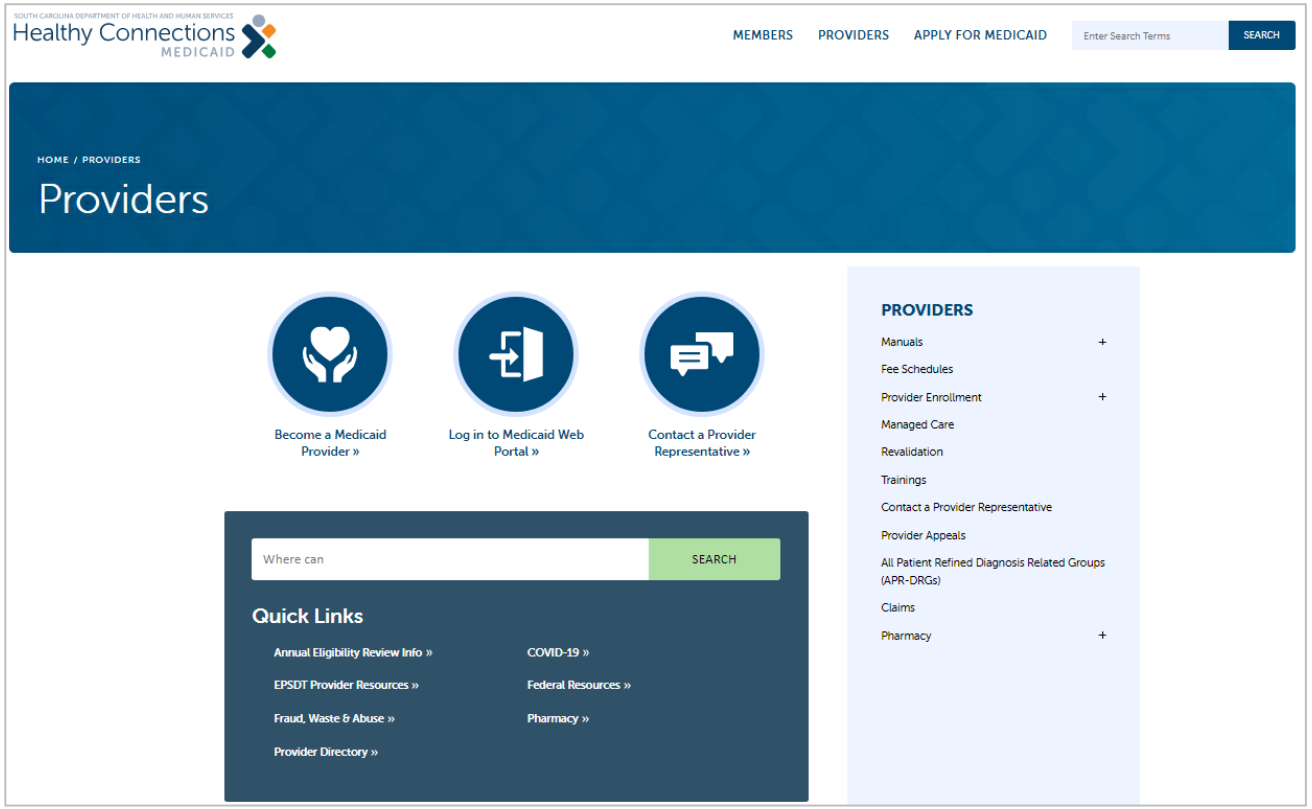
Benefit Partners

Healthy Connections

- Healthy Connections allows the member to change their address, report changes to their health plan and see exactly what Medicaid covers.
- For more information, members can:
  - Call 888-549-0820 (TTY: 888-842-3620)
  - Visit www.scdhhs.gov

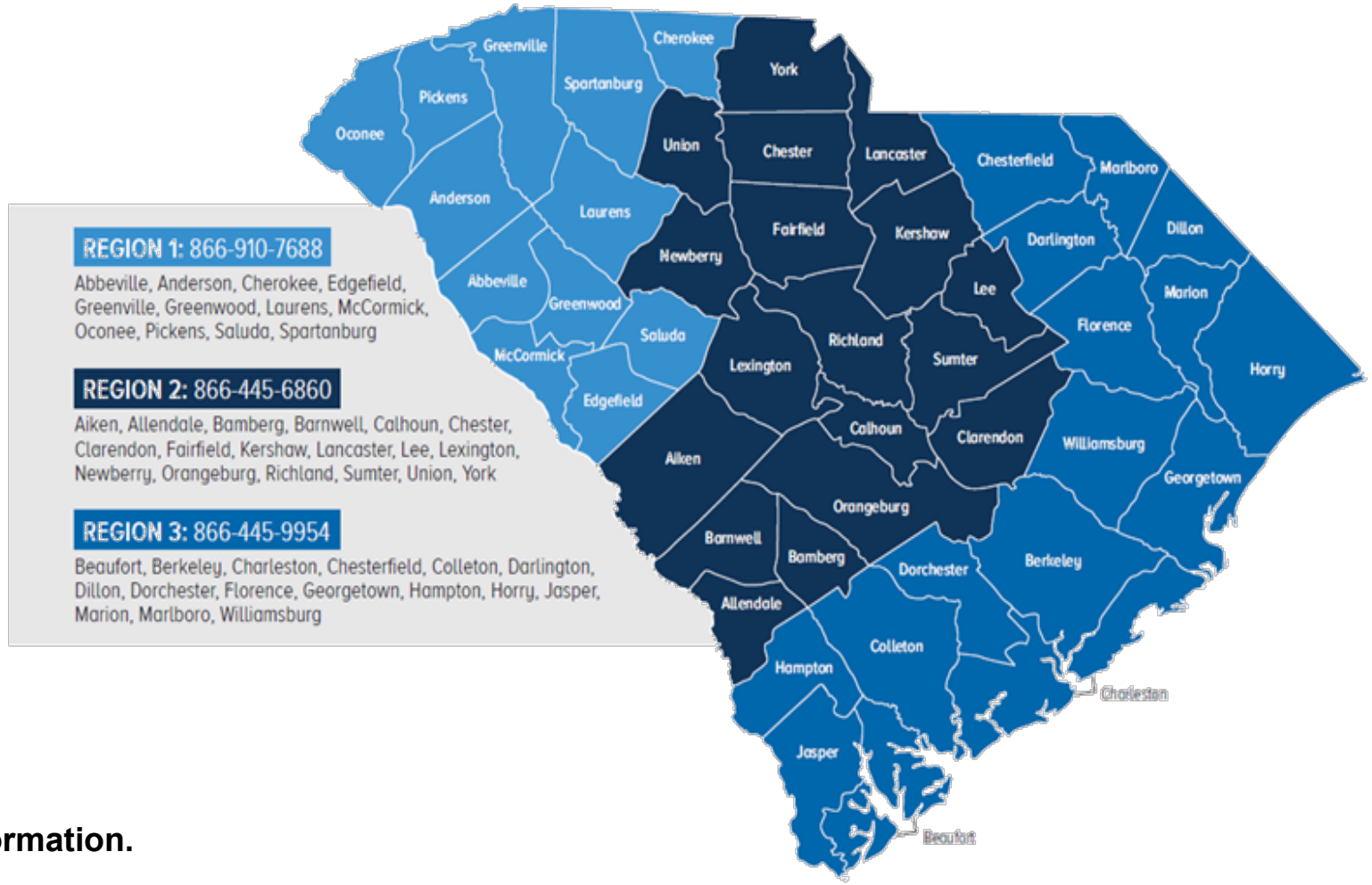
Healthy Connections (Continued)

- Healthy Connections allows providers to register their NPI to become a Medicaid provider, review manuals, check fee schedules and more.
- The South Carolina Department of Health and Human Services (SCDHHS) **requires** separate NPI registration for each group and individual provider.
  - Once registered, the NPI must match the Medicaid ID number on the claim.
- For more information, providers can also:
  - Call 888-549-0820 (TTY: 888-842-3620)
  - Visit www.scdhhs.gov



Modivcare – Transportation Services

- Modivcare offers transportation for non-emergent medical services.
- Requests should be made at least three days before the appointment.
  - Be sure to have the member's information available when making a reservation.
- Available Monday – Friday from 8 a.m. to 5 p.m. EST



Visit www.Modivcare.com/facilities/sc for more information.

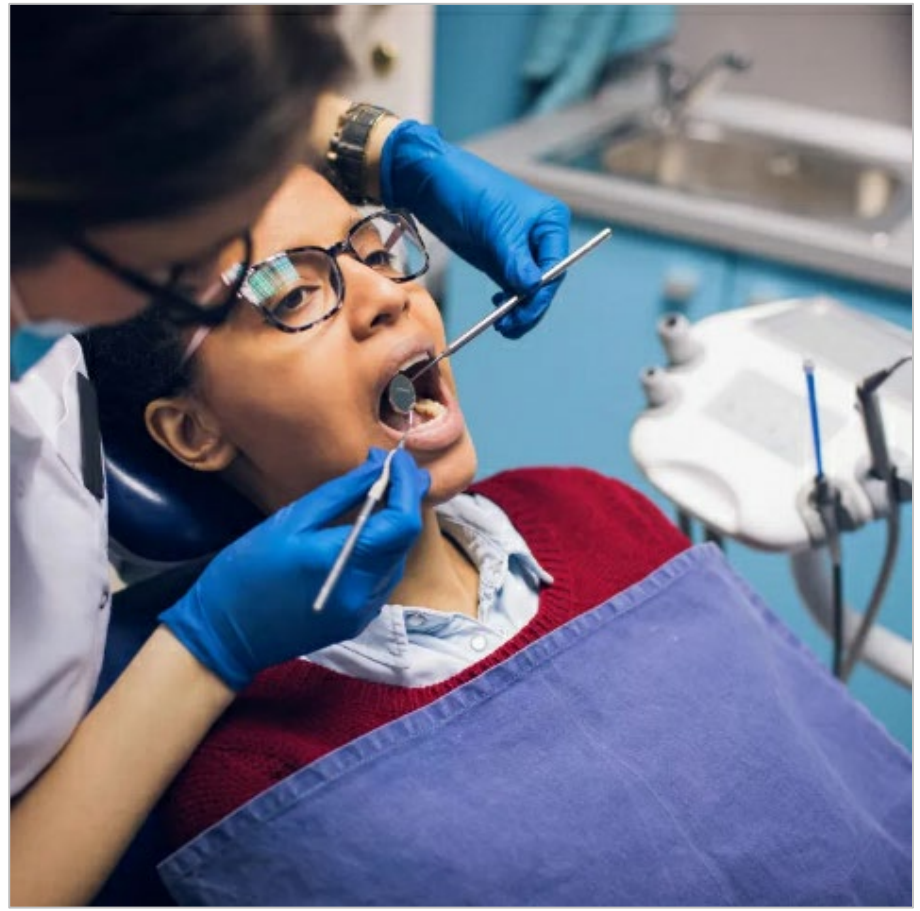
Vision Service Provider (VSP)

- VSP handles the vision coverage for our Healthy Blue members.
  - Only applies to routine vision services.
- The provider must participate in the VSP network.
- Call 800-877-7195 for information on the available vision options.
  - Available Monday – Saturday from 6 a.m. to 5 p.m. PST

Visit www.vsp.com for more information.

DentaQuest

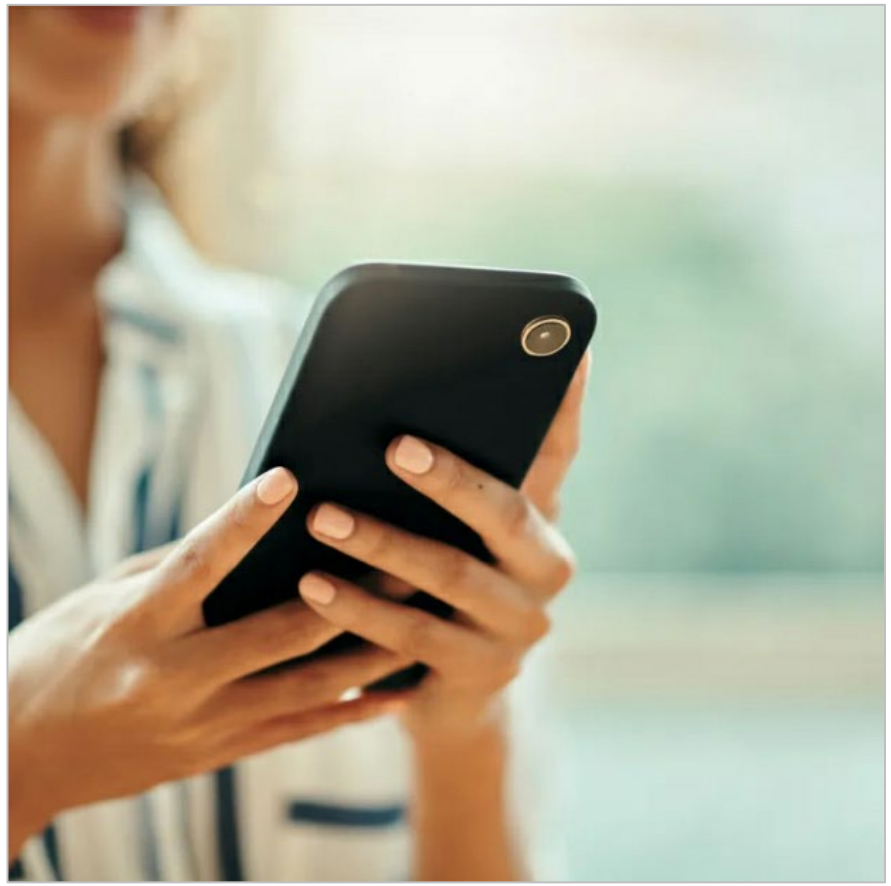
- DentaQuest providers dental coverage for members 21 years of age or younger.
- For coverage details, call 888-307-6552.



Visit www.dentaquest.com for more information.

Relay South Carolina

- Relay South Carolina offers members that have hearing or speech loss a way to communicate by telephone.
- Members can dial 711 or call 800-735-2583.



Visit www.relaysouthcarolina.com for more information.

ProgenyHealth

- ProgenyHealth specializes in neonatal care management.
- They promote healthy outcomes for premature and medically complex newborns.
- ProgenyHealth has a team of neonatologists, pediatricians, and neonatal nurse care managers that collaborate closely with the member.
- Members have 24/7 access by:
  - Calling 888-832-2006.
  - Faxing a request to 877-471-0549.

Member Benefits

Member Identification Cards

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

Reviewing Fee Schedules and Manuals

Fee Schedules

Listed by provider specialty type

Codes (including modifiers) listed on fee schedules are considered for reimbursement

Medicaid Manage 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

Visit www.scdhhs.gov and select Providers. Then choose fee schedule or manual.

DME and Home Health

Durable Medical Equipment

- Covered when prescribed to preserve bodily functions or prevent disability
- Use modifiers to identify rental or purchase
- Medical documentation is required for both rentals and purchases
- Customized items, some CPT codes, and OON providers require prior authorization (PA)

Home Health

- Includes intermittent skilled nursing, home health aides, physical, occupational and speech therapy and physician-ordered supplies
- Limit of 50 visits per benefit year (July 1 – June 30)
- All home health care services require PA (authorized for a 30-day duration)

Therapy Services and BabyNet

Physical, Occupational and Speech Therapy

All members have 420 units per benefit year

(July 1 – June 30)

PA is required for codes 97022, 97140, 97150, 97166, 97167 and all other codes beyond the allowed visits

BabyNet

Includes services for ages zero to three with developmental delays

All current Medicaid services are included

Emails for SC Healthy Connections BabyNet program should be sent to BabyNet@scdhhs.gov

Routine Vision

Routine Vision

Covered through VSP

Medically necessary services covered during the 365-day period when approved

Note: Call VSP for prior authorization.

Claims should be submitted directly to VSP (electronically or by mail)

Covered Service	Members under 21	Members 21 and older
Routine eye exam	One, every 12 months	One, every 12 months
Eyeglasses (Frames, lenses and fitting)	One pair, every 12 months	One pair, every 24 months

Note: Services are diagnosis driven and are typically rendered by an optometrist.

VSP Covered Codes

Type of Service	CPT Codes
Exams and Office Visits	92002, 92004, 92012, 92014, 92015 (routine only)
Evaluation and Management (E&M) Services	99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215
Online Digital Evaluation and Management (E&M) Services	99421, 99422, 99423
Telephone Evaluation and Management (E&M) Services	99441, 99442, 99443
Consultations	99242, 99243, 99244, 99245
Interprofessional telephone/internet assessment and management services	99446, 99447, 99448, 99449, 99451, 99452
Urgent/Emergency Care	99050, 99051, 99058
Special Ophthalmological Services	92020, 92025, 92060, 92071, 92081, 92082, 92083, 92100, 92132, 92133, 92134, 92136, 92201, 92202, 92227, 92228, 92250, 92260, 92270, 92273, 92274, 92283, 92284, 92285, 92286, 92287, 92499, 95930, 99070
Radiology/Diagnostic Ultrasound	76510, 76511, 76512, 76513 76514, 76516, 76519, 76529
Eye and Ocular Adnexa Services	65205, 65210, 65220, 65222, 65430, 65435, 67820, 67938, 68020, 68040, 68761, 68801, 68810, 68815
Pathology and Laboratory	83516, 83861, 87809

Note: List may not be all inclusive and is subject to change. Also, be mindful of the diagnosis codes.

Laboratory Services

Avalon Healthcare Solutions provides laboratory benefit management services.

- Anatomical pathology and cytology specimens do not require prior authorization.
- Certain labs, such as genetic testing, may require prior authorization.
    - This includes STAT labs.

Note: STAT labs can be sent to a contracted hospital.

Clinical Laboratory Improvement Amendment

To be considered for reimbursement of clinical laboratory services, a valid CLIA certificate identification number must be reported on a 1500 Health Insurance Claim Form (CMS-1500). The CLIA certificate identification number must be submitted in one of the following manners

Claim Format and Elements	CLIA Number Location Options	Referring Provider Name and NPI Location Options	Servicing Laboratory Physical Location
CMS-1500	Must be represented in field 23	Submit the referring provider name and NPI number in fields 17 and 17b, respectively.	Submit the servicing provider name, full physical address and NPI number in fields 32 and 32A, respectively, if the address is not equal to the billing provider address. The servicing provider address must match the address associated with the CLIA ID entered in field 23.
HIPAA 5010 837 Professional (Clearinghouse)	Must be represented in the 2300 loop, REF02 element, with qualifier of X4 in REF01	Submit the referring provider name and NPI number in the 2310A loop, NM1 segment.	Physical address of servicing provider must be represented in the 2310C loop if not equal to the billing provider address and must match the address associated with the CLIA ID submitted in the 2300 loop, REF02.

Access and Availability

The following guidelines are **required** for our in-network providers.

Primary Care	
Routine visit	Available within four to six weeks
Urgent, non-emergent visit	Available within 48 hours
Emergent visit	Available immediately upon presentation at a service delivery site

Specialist Care	
Routine visit	Available within four weeks; maximum of 12 weeks for unique specialists
Urgent medical condition care	Available within 48 hours of referral or notification from primary care physician
Emergent visit	Available immediately upon referral

Note: Wait times should not exceed 45 minutes for a scheduled appointment of a routine nature.

Prior Authorization

Prior Authorization Lookup Tool

- The lookup tool went into effect July 1, 2024.
- It is used for outpatient services only.
- Benefit coverage should still be verified before rendering services.

Providers>Authorization and Eligibility>Prior Authorization

Prior Authorization Lookup Tool - 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

Prior Authorization Methods

Medical Forms Resource Center

www.formsresource.center

Request Peer-to-Peer

For additional assistance:
866-757-8286

My Insurance Manager

My Insurance Manager

Fast Track Option

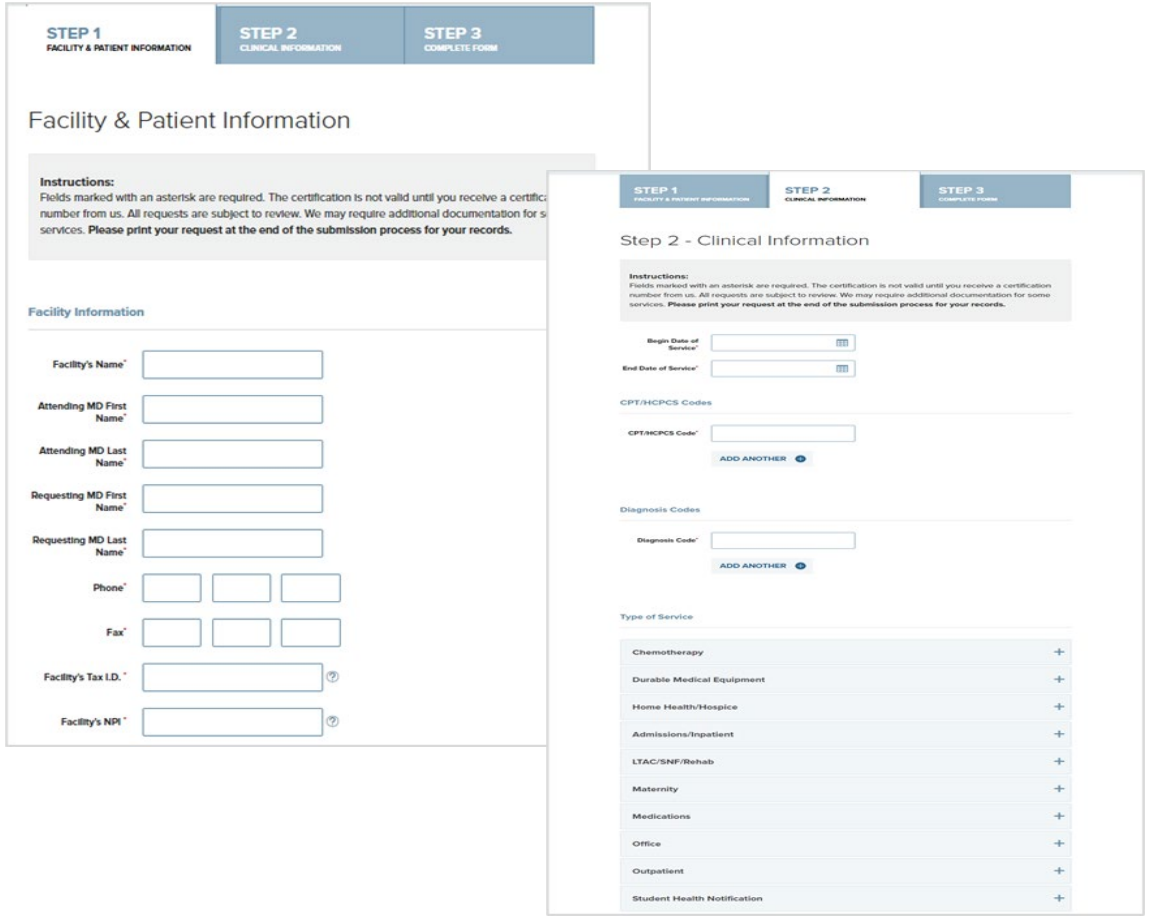
Custom Request

Phone – Provider Service

866-757-8286

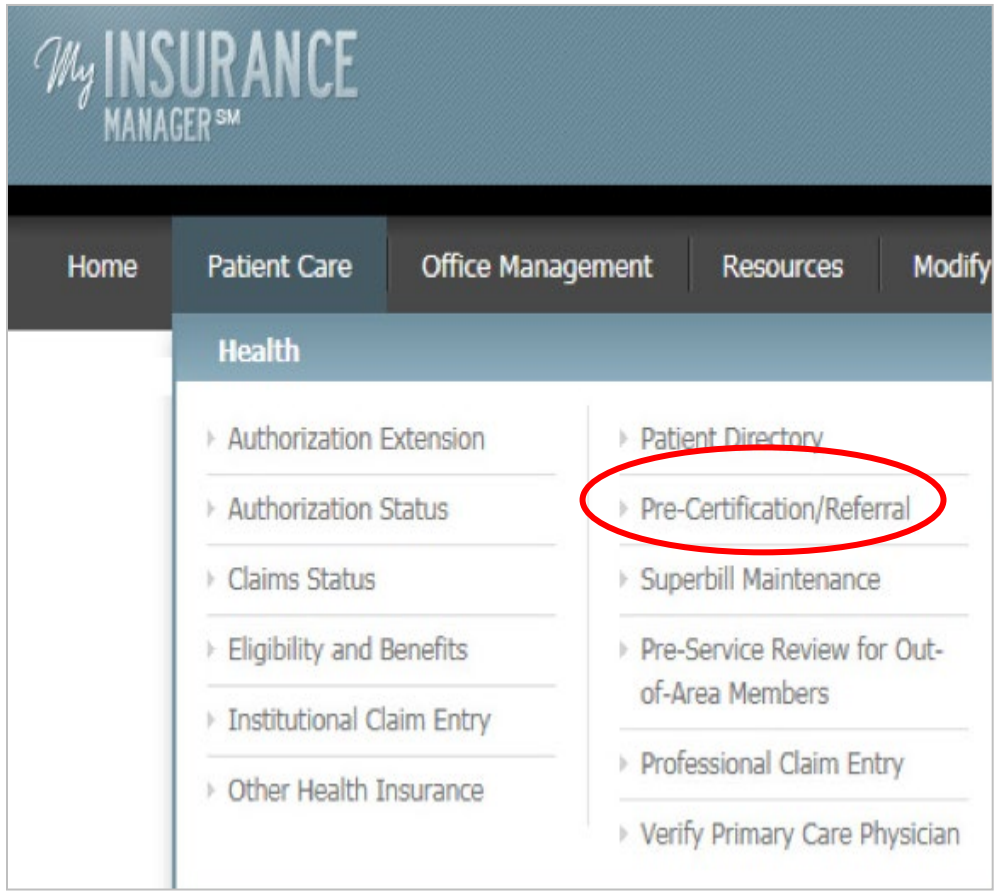
Medical Forms Resource Center

- The Medical Forms Resource Center (MFRC) is an online prior authorization submission tool.
  - Offers various types of requests.
  - Guides you through the process.
  - Receives priority processing.
- Complete requests in three steps:
  1. Enter the facility and patient details.
  2. Include all required information and clinical details.
  3. Submit the request.



My Insurance Manager

- My Insurance Manager is another online tool that allows you to submit prior authorization requests.
- Includes two options:
  - Fast-track
    - Offers several predetermined authorization requests based on the volume received.
    - Includes specific codes based on the type of service.
    - The authorization number is typically provided after submission.
  - Custom request
    - When a fast-track request is unavailable, you can create a custom request.
    - The request will pend for further review.



Phone Requests

If requesting a prior authorization by phone, the following information is required:

- Member's name, date of birth, Medicaid ID number and address
- ICD-10 codes
- CPT or HCPCS codes and unit amounts (when applicable)
- Date(s) of service
- Level of care (when applicable)
- Requesting provider's Tax ID, NPI, address, phone and fax numbers
- Servicing provider's Tax ID, NPI, address, phone and fax numbers
- If NICU*, also include the mother's name, date of birth and Medicaid ID number

Neonatal intensive care unit

Upcoming Prior Authorization Changes

- Coming soon, we will implement a new method to request a prior authorization (PA).
- Providers will still sign into My Insurance Manager but will be routed to a new web-based application, powered by Cohere Health, that will enhance the efficiency of PA decisions.
- Benefits of this change include:
  - Accelerates and expands real-time approvals.
  - Enables a more seamless provider experience.
  - Decreases administrative efforts.
  - Meets new CMS and NCQA requirements that shorten the time for prior authorization decisions.
- The process for third-party vendors like Evolent, Avalon and Novologix will remain the same.

Centers for Medicare and Medicaid Services (CMS); National Committee for Quality Assurance (NCQA)

Upcoming Prior Authorization Changes (Continued)

- The new process will:
  - Verify member eligibility.
  - Verify the provider's network.
  - Check prior authorization requirements.
    - This includes medical record requirements for review.
  - Verify procedure and diagnosis codes.
  - Expand fast-track approvals and real-time responses.
  - Align with our clinical policies.
  - Allow for digital submission of medical records.
- Review the available webinars and learning center to get prepared.
- For more information, feel free to contact your Provider Relations Consultant.

Claims

How to Submit Claims

You have **365 days** to submit an original or corrected claim. For dates of service **on or before Dec. 31, 2023**, use the following options:

Electronically* (Clearinghouse)

Payer ID: 00403

E-Solutions: 800-470-9630
(Set-up and information)

Online

Availity
(www.availity.com)

Hard copy

Healthy Blue
Attn: Medicaid Claims
P.O. Box 100124
Columbia, SC 29202-3124

Preferred method.

Availity, LLC and E-Solutions are independent companies providing administrative support services on behalf of Healthy Blue.

How to Submit Claims (Continued)

You have **365 days** to submit an original or corrected claim. For dates of service **on or after Jan. 1, 2024**, use the following options:

Electronically* (Clearinghouse)

Payer ID: 00403

Electronic Data Interchange (EDI): EDI.Services@bcbssc.com

Online

My Insurance Manager

Hard copy

Healthy Blue
Attn: Medicaid Claims
P.O. Box 100317
Columbia, SC 29202-3317

Preferred method.

Need 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:
866-757-8286

Step 3

File a Provider Dispute

Provider Disputes

- Be sure to submit the appropriate Healthy Blue Provider Dispute Form when submitting your request.

Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

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.

How to Submit Provider Disputes

A provider dispute is a request to investigate a finalized claim. It must be submitted **within 90 calendar days** from the date of the explanation of payment. Use one of the following options:

Verbally	Call Provider Service at 866-757-8286.
Email	Send an email to HBProviderService@HealthyBlueSC.com.
Written	Mail it to 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.

Common Claim Denials

Member eligible for health care with another carrier	Non-covered services	Duplicate charges paid	Miscellaneous (Timely filing, Worker's Compensation, etc.)
Member should update their information with the State and Healthy Blue	Verify eligibility and benefits before rendering services and review the SCDHHS fee schedules and manuals	Allow time for the claim to process and verify the status of the claim online before resubmitting	Submit claims in a timely manner and verify whether services could be the result of an accident

Balance Billing

What is it?

Billing a member for an amount not reimbursed by Healthy Blue on a claim

What should be done?

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 as though you received too much money, you can complete the Overpayment Refund Form to return the payment.
- Be sure to mail the check to the address listed on the form.

Providers>Claims>Refunds Process

Healthy Blue
BlueChoice® HealthPlan of SC

Healthy Connections

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

Provider Incentives

Note: Provider incentives only apply to primary care physicians.

Notification of Pregnancy and CenteringPregnancy

Notification of Pregnancy

- 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 pregnancy diagnosis date

CenteringPregnancy

- 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 5th visit), pregnancy diagnosis and billed charges of $175

Screening, Brief Intervention and Referral to Treatment

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

Well-Child

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 and CPT® Category II Codes

Sports Physical

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

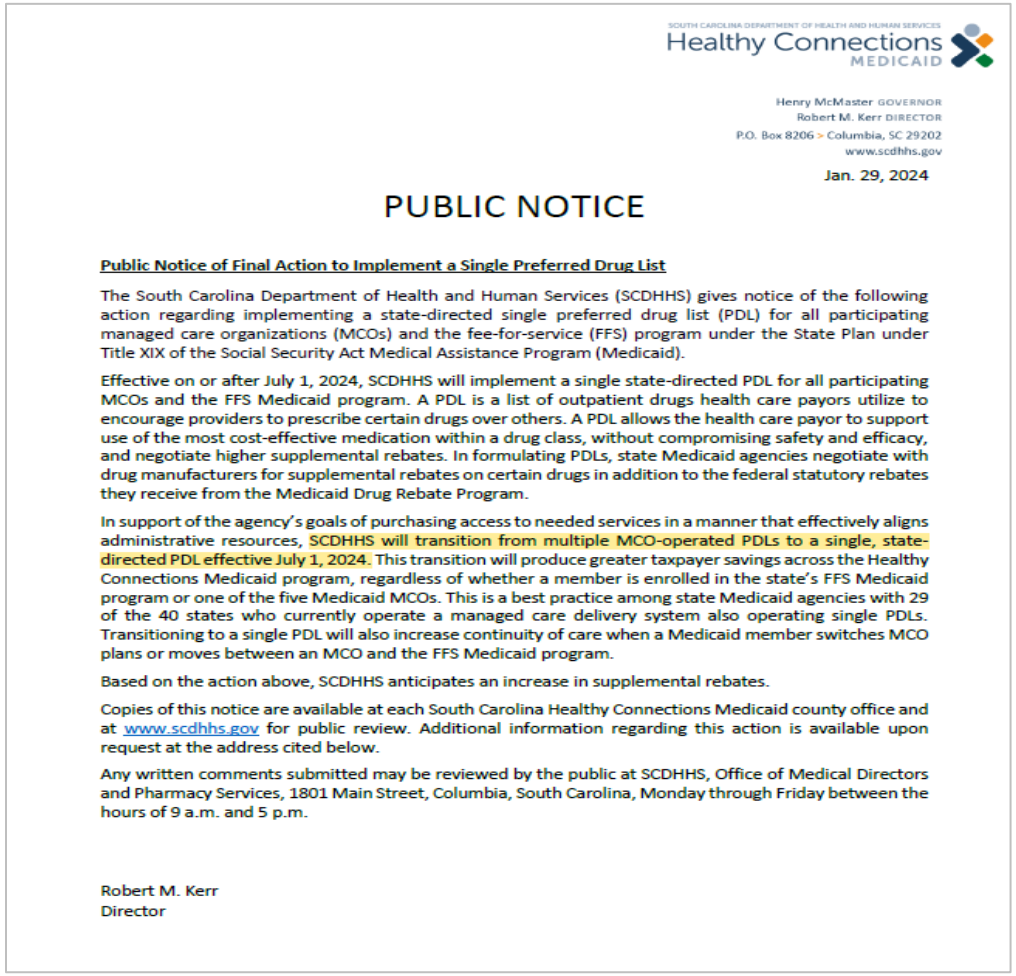
CPT Category II Codes

- Incentive varies per code
- Each code has diagnosis, age and criteria requirements
- List of codes available online:
  Providers>Quality>Quality Resources

Pharmacy

Single Preferred Drug List

- On July 1, 2024, SCDHHS transitioned from multiple MCO-operated preferred drug lists (PDLs), to a single, state directed preferred drug list (sPDL).



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Robert M. Kerr DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Jan. 29, 2024

PUBLIC NOTICE

Public Notice of Final Action to Implement a Single Preferred Drug List

The South Carolina Department of Health and Human Services (SCDHHS) gives notice of the following action regarding implementing a state-directed single preferred drug list (PDL) for all participating managed care organizations (MCOs) and the fee-for-service (FFS) program under the State Plan under Title XIX of the Social Security Act Medical Assistance Program (Medicaid).

Effective on or after July 1, 2024, SCDHHS will implement a single state-directed PDL for all participating MCOs and the FFS Medicaid program. A PDL is a list of outpatient drugs health care payors utilize to encourage providers to prescribe certain drugs over others. A PDL allows the health care payor to support use of the most cost-effective medication within a drug class, without compromising safety and efficacy, and negotiate higher supplemental rebates. In formulating PDLs, state Medicaid agencies negotiate with drug manufacturers for supplemental rebates on certain drugs in addition to the federal statutory rebates they receive from the Medicaid Drug Rebate Program.

In support of the agency's goals of purchasing access to needed services in a manner that effectively aligns administrative resources, SCDHHS will transition from multiple MCO-operated PDLs to a single, state-directed PDL effective July 1, 2024. This transition will produce greater taxpayer savings across the Healthy Connections Medicaid program, regardless of whether a member is enrolled in the state's FFS Medicaid program or one of the five Medicaid MCOs. This is a best practice among state Medicaid agencies with 29 of the 40 states who currently operate a managed care delivery system also operating single PDLs. Transitioning to a single PDL will also increase continuity of care when a Medicaid member switches MCO plans or moves between an MCO and the FFS Medicaid program.

Based on the action above, SCDHHS anticipates an increase in supplemental rebates.

Copies of this notice are available at each South Carolina Healthy Connections Medicaid county office and at www.scdhhs.gov for public review. Additional information regarding this action is available upon request at the address cited below.

Any written comments submitted may be reviewed by the public at SCDHHS, Office of Medical Directors and Pharmacy Services, 1801 Main Street, Columbia, South Carolina, Monday through Friday between the hours of 9 a.m. and 5 p.m.

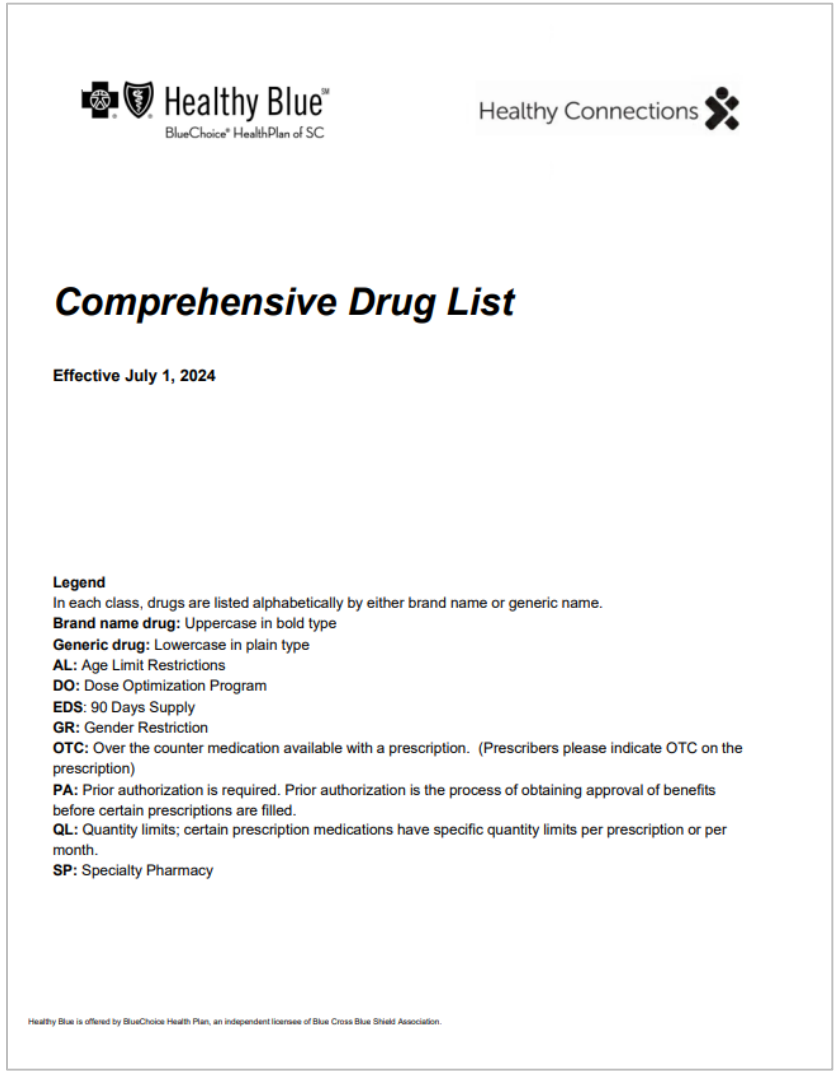
Robert M. Kerr
Director

What is a sPDL?

- The sPDL is a DHHS provided drug list for pharmacy benefit (outpatient drugs) that both fee-for-service Medicaid and all managed care plans must follow for coverage.
  - Drugs are noted as preferred, preferred with criteria or non-preferred.
  - The sPDL can be found at: https://southcarolina.fhsc.com/providers/pdl.asp.
- **The sPDL drug list is maintained by DHHS and are managed drugs.**
- **The sPDL does not encompass all medications in the universe.**
- All other drugs not addressed in the sPDL are **non-managed drugs**.
  - Examples include oral contraceptives, oral cancer drugs and most over-the-counter (OTC) products.

Comprehensive Drug List

The Healthy Blue Comprehensive Drug List can be found at: https://www.healthybluesc.com/providers/pharmacy.



Healthy Blue BlueChoice® HealthPlan of SC

Healthy Connections

Comprehensive Drug List

Effective July 1, 2024

Legend
In each class, drugs are listed alphabetically by either brand name or generic name.
Brand name drug: Uppercase in bold type
Generic drug: Lowercase in plain type
AL: Age Limit Restrictions
DO: Dose Optimization Program
EDS: 90 Days Supply
GR: Gender Restriction
OTC: Over the counter medication available with a prescription. (Prescribers please indicate OTC on the prescription)
PA: Prior authorization is required. Prior authorization is the process of obtaining approval of benefits before certain prescriptions are filled.
QL: Quantity limits; certain prescription medications have specific quantity limits per prescription or per month.
SP: Specialty Pharmacy

Healthy Blue is offered by BlueChoice Health Plan, an independent licensee of Blue Cross Blue Shield Association.

Important Pharmacy Changes Due to the sPDL

Continuity of Care

- Current members using a medication that the sPDL now lists as non-preferred will not be required to change to a preferred medication until Jan. 1, 2025.
- We will send additional information soon.

Prior Authorizations

- Previously approved prior authorizations for medications that the sPDL now lists as non-preferred will have an amended end date no later than Dec. 31, 2024.
- We will send additional information soon.

Brand over Generic

- Certain brand name medications are covered versus generic.
- We are required to pay for the brand name only.
- Pharmacies can dispense the generics as a 3-day emergency supply.

State Mandated Brand Name Preferred List

Adcirca	Benicar HCT	Daytrana	Firvanq	Narcan Nasal	Protonix Suspension	Saphris	Trileptal Suspension
Adderall XR	Butrans	Dexilant	Flovent HFA*	Natroba	Rapamune Solution*	Spiriva Handihaler	Vascepa
Advair Diskus	Carbatrol	Elidel	Humalog Jr Kwikpen**	Nexium Suspension	Rapamune Tablet*	Suboxone Film	Ventolin HFA
Advair HFA	Celontin	Emend Cap	Humalog Mix Kwikpen**	Novolog Cartridge**	Relpax	Symbicort	Vigamox
Alphagan P 0.1%, 0.15%	Chantix*	Emend Pack	Humalog Kwikpen**	Novolog Mix Flexpen**	Restasis	Tegretol XR	Vimpat Solution
Amitiza	Chantix Pack*	Epipen**	Humalog Vial**	Novolog Mix Vial	Retin-A Cream	Tekturna	Vimpat Tablet
Apriso	Ciprodex*	Epipen Jr**	Imitrex Nasal	Novolog Flexpen**	Retin-A Gel	Testim Gel 1% Packet	Vyvanse Capsule
Azopt	Combigan	Exelon Patch	Lantus Solostar	Novolog Vial**	Sabril Powder Pack	Toviaz	Vyvanse Chewable
Banzel Susp	Concerta	Farxiga	Lantus Vial	Pentasa	Sabril Tablet	Transderm-Scop	Xigduo XR
Banzel Tab	Copaxone 20mg/ml dose	Finacea	Lumigan	Pradaxa	Sandimmune Capsule**	Travatan-Z	

* = Brand Name AND Generic are BOTH Preferred (various reasons including drugs being discontinued, shortages, etc.)

** = Brand and AUTHORIZED GENERIC (only) are BOTH Preferred

This list is current as of 7/12/2024 and is subject to change at any time, should not be considered all-inclusive, and cannot be used for claims payment. **FOR INFORMATIONAL PURPOSES ONLY**.

Pharmacy vs. Medical Benefit

Pharmacy Benefit

- Medications at retail, specialty and mail order pharmacies.
- The drug is self-administered.
- Use the Comprehensive Drug Lookup Tool: https://client.formularynavigator.com/Search.aspx?siteCode=1404420163

Prior Authorization Information through CarelonRx

- Phone: 844-410-6890
- Fax: 844-512-9005
- ePA Portal: Covermymeds
- Review time: 24 hours

Medical Benefit

- The drug is provider-administered in the office, infusion center, etc.
- Use the Medical Specialty Drug List: https://www.healthybluesc.com/providers/pharmacy

Prior Authorization Information through CVS/Novologix

- Phone: 844-345-2803
- Fax: 866-494-9927
- Online Portal: My Insurance Manager
- Review time: Urgent, 72 hours; Standard, 14 days

Pharmacy at a Glance

Prescription Limits

- There is no limit on the number of prescriptions a member can fill each month, but some medications may require prior authorization.

Specialty Medications

- These are high-cost medications used to treat difficult conditions.
- Noted as SP (specialty) on the drug lookup tool.
- Must be dispensed through a preferred specialty pharmacy (833-262-1726).
- If circumstances require immediate access, we allow a one-time override at a retail pharmacy.

Vaccines

- All FDA approved and Advisory Committee on Immunization Practices (ACIP) recommended vaccines are covered for adults and children.

Pharmacy at a Glance (Continued)

Extended Day Supplies (EDS)

- 90-day supply of certain medications and are available at retail or mail.
- Noted as EDS on our drug lookup tool.
- Pertains to certain medications in the following categories:
  - Asthma
  - Cholesterol
  - Oral diabetes
  - Hypertension

Mail Order and Home Delivery

- An extra benefit available on most medications.
- Controlled substances are excluded.
- Up to 31-day supply or 90-day supply for certain medications (noted above)
- Phone: 833-396-0309
- Fax: 833-389-4172

Pharmacy at a Glance (Continued)

Contraceptives

- Pharmacy benefit covers oral contraceptives, contraceptive devices and OTC contraceptives.
- Implantable devices are available through the medical benefit, but injectable contraceptives are available under the pharmacy or medical benefit.
- Member can receive up to a year supply of contraceptives through the pharmacy benefit in one fill.

Diabetic Supplies

- Both the pharmacy and medical benefit cover preferred diabetic supplies: blood glucose monitors, test strips, lancets and continuous glucose monitors.

OTC Medications

- Select OTC medications, when prescribed by a licensed practitioner, are covered under the pharmacy benefit. A written prescription is required.

Analgesics	Antacids	Anti-diarrheals	Antihistamines, including generic loratadine	Anti-inflammatories	Anti-ulcer medications, including Prilosec	Benzoyl peroxide
Contraceptive devices (condoms, foams and creams)	Hematinics	Hydrocortisone	Laxatives/stool softener	Pediatric vitamins	Pediculicides	Prenatal vitamins
Smoking cessation products (generic nicotine patches and gum)	Topical anti-fungal preparations	Topical antibiotics	Topical anti-parasitics	Vaginal anti-fungal preparations		

Managing Prescriptions

Transition Fill

- If a member leaves another plan or fee-for-service Medicaid to join Healthy Blue, they are eligible for a transition fill for medications needing approval for up to 90 days after they join Healthy Blue.
    - The member is only allowed a one-time fill for a 30-day supply during the transition period.
    - The first refill for a non-covered medication after the initial transition fill or following the identified transition period will reject per the Health Blue Comprehensive Drug List.
    - Prior authorization is required per policy.

Emergency Fill

- Healthy Blue network pharmacies may provide a 72-hour emergency supply of medication to members who have an immediate need to start a medication that is being reviewed for coverage through the prior authorization process.
- The network pharmacy may enter the designated override code provided and submit a claim for the 72-hour supply of medication.
- A call is not needed to request the emergency supply.

Pharmacy Resources

- Healthy Blue Provider website: https://www.healthybluesc.com/providers/pharmacy
- Comprehensive Drug Lookup Tool: https://client.formularynavigator.com/Search.aspx?siteCode=1404420163
- SCDHHS sPDL: https://www.scdhhs.gov/providers/pharmacy
- Prior Authorization Form: https://southcarolina.fhsc.com/Downloads/provider/SCRx_PAform_GeneralMeds.pdf

Behavioral Health

Covered Services for Fee-for-Service

SCDHHS covers some behavioral health services

SCDHHS is responsible for most waiver services

Covered Services with Healthy Blue

- Inpatient care at a general acute hospital
- Professional psychiatric care
- Outpatient care*
- Substance use treatment services**
- Autism care
- Psychiatric residential treatment facility care
- Rehabilitative behavioral health care
- Opioid treatment program
- Institute for mental diseases
- School- based rehabilitative therapy***
- Assertive Community Treatment****

***Services must be provided by:**

- Licensed Independent Practitioners (LIPs)
- Group Practices
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Psychiatrists
- Advanced Nurse Practitioners
- Community Mental Health Centers(SC DMH & MUSC)

****Services must be provided by:**

- Department of Alcohol and Other Drug Abuse Services (DAODAS)

*****Effective July 1, 2022**

******Effective July 1, 2023**

New Covered Service for Behavioral Health

- The following services have been added to the benefit coverage for behavioral health.

RBHS Moratorium Lift
(**Effective Jan. 1, 2024**)

Hospital-based Crisis Stabilization Services
(**Effective Jan. 1, 2024**)

Intensive In-home Supports: Evidence-based Services
(**Effective Jan. 1, 2024**)

Transplant and Developmental Evaluation Centers
(**Effective Feb. 1, 2024**)

DAODAS/301s and Medical Services
(**Effective May 1, 2024**)

Intensive In-home Supports: Homebuilders Services
(**Effective July 1, 2024**)

Peer Support Services
(**Effective July 1, 2024**)

Targeted Case Management and Moratorium Lift
(**Effective July 1, 2024**)

ASD – Phase II
Added codes 97152, 97157, 0362T and 0373T)
(**Effective July 1, 2024**)

Note: Review the manual for more information on these updates.

School-Based Rehabilitative Therapy

SCDHHS provides Medicaid reimbursement for medically necessary services provided in the Local Education Agency

Includes, but not limited to, children under the age of 21 who have or are at risk of developing sensory, emotion, behavioral or social impairments, disabilities and more

School-Based Rehabilitative Therapy – Billing

Claim Requirements

- School ID
- Place of Service '03'
- Modifier H1* or H2**

*Refers to licensed or certified professionals allowed to practice at the independent level.

Includes LPC, LMFT, LISW, LPES, Certified School Psychologist II and III

**Refers to professionals who require supervision and co-signature on their diagnostic assessment (used to confirm medical necessity).

Includes LMSW, MHP and Certified School Psychologist I

Learn more at www.scdhhs.gov:
Providers>Manual>Local Education Agencies Services Provider Manual

Note: Billing modifiers must match the credentials of the individual rendering the service. Also, the place of service code should be placed in the 2300 NTE segment of the claim (electronically) or on the Claim Information page of My Insurance Manager.

Rehabilitative Behavioral Health Services

- RBHS services can be rendered by these provider types.
- Prior authorization is required for all services and providers.

LIPs[1]	LACs[2]	DAODAS[3]	DMH[4]
DOE[5]	DJJ[6]	DSS[7]	COC[8]

[1]Licensed Independent Practitioners

[2]Licensed Addiction Counselors

[3]Department of Alcohol and Other Drug Abuse Services

[4]South Carolina Department of Mental Health

[5]South Carolina Department of Education

[6]South Carolina Department of Juvenile Justice

[7]South Carolina Department of Social Services

[8]South Carolina Continuum of Care

Institutes for Mental Disease

Eligible Members	Prior Authorization	Certificate of Need
Ages 0 – 21	Phone: 866-902-1689 (Select option 3.)	Fax: 877-664-1499

Note: Institutes for Mental Disease are required to have 16 or more beds.

Opioid Treatment Program

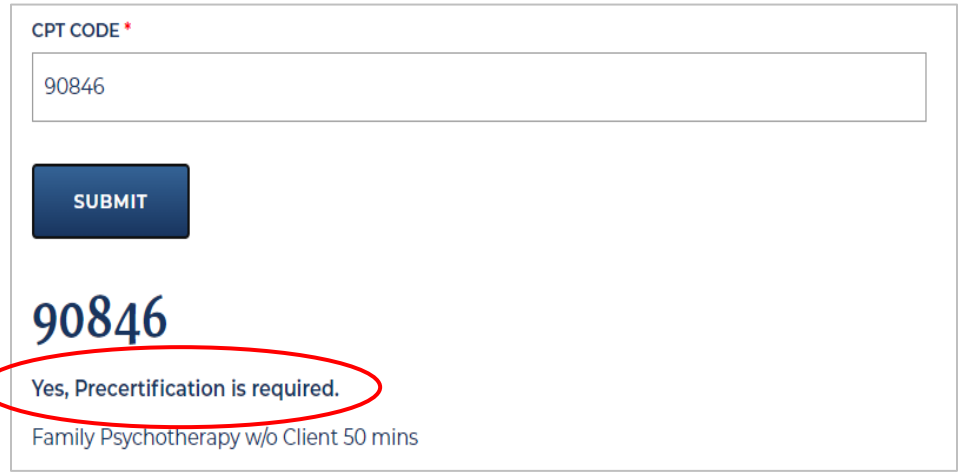
No age restrictions for participation

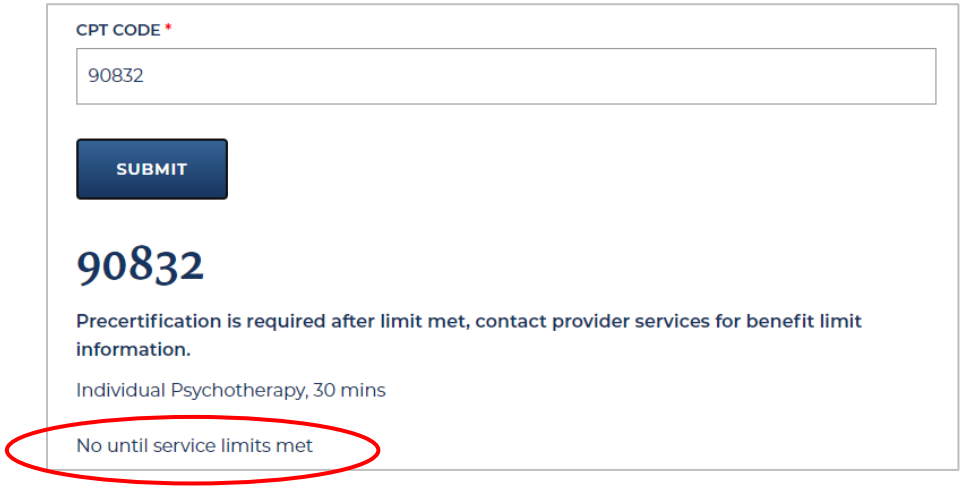
No PA required

Note: Be sure to refer to the Provider Manual for frequency limitations.

Prior Authorization for Behavioral Health

- Prior authorization (PA) requirements may vary per code.
- Some codes require an automatic PA, while some only require a PA once the limit is met.
- Verify PA requirements using the PA Lookup Tool.

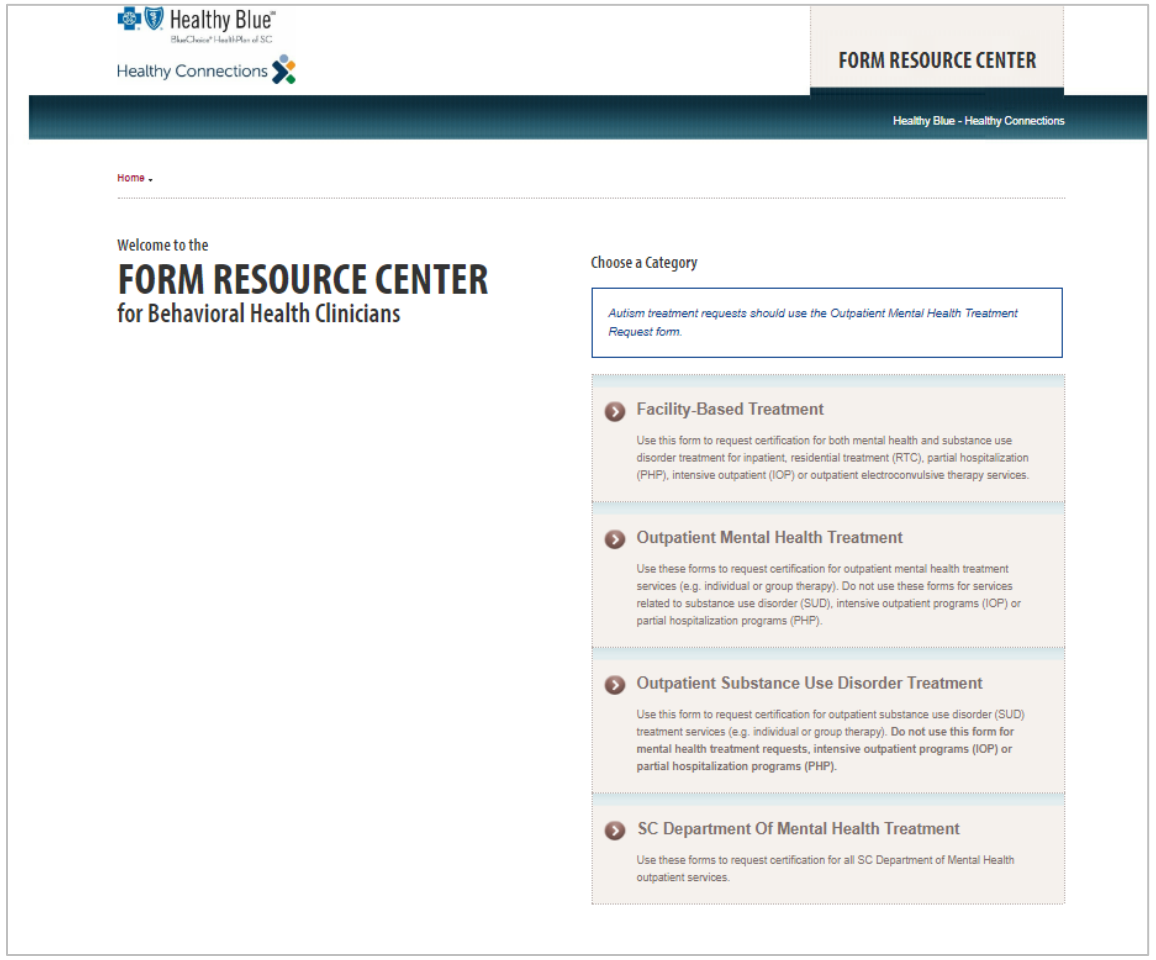




Note: Be sure to verify eligibility and benefits before rendering services.

Forms Resource Center for Behavioral Health

- Use the Forms Resource Center (FRC) to submit prior authorization requests.
  - This process will end soon.
- **Allow up to 14 days** to process the request (from the submission date).
- Check the status in My Insurance Manager.



Providers>Authorization and Eligibility>Prior Authorization

Stigmas and Behavioral Health

What is a stigma?

A mark of disgrace associated with a particular circumstance, quality or person

How are stigmas associated with behavioral health?

Misguided views

Religious reasons

News reports

Providers>Patient Care>Behavioral Health

Types of Stigmas and Their Effects

Public	Systemic	Self
Discrimination by others	*Reduced access to care*	*Internalization of stereotypes*
Loss of employment	Loss of opportunities	Lowered self-esteem

Overcoming and Coping with Stigmas

- Educate yourself and patients
- Have open discussions about mental health
- Be honest about treatment
- Assist patient with getting the proper care they need
- Encourage patients to not be ashamed
- Encourage patients to not isolate themselves
- Encourage patients to join support groups

Behavioral Health Resources

- SCDHHS: www.scdhhs.gov/providers
- FRC: https://healthyblue.companionbenefitalternatives.com/
- Joining the CBA Network: cba.provrep@companiongroup.com
- Healthy Blue Behavioral Health Contracting: HealthyBlueBHContracting@bcbssc.com
- Companion Benefit Alternatives (CBA): 800-868-1032

Provider Enrollment

Provider Enrollment Applications and Forms

Applications	Used for…
Individual Enrollment	New practitioners that want to enroll with BlueCross (***not for Behavioral Health***)
Group Practice Enrollment	New groups that want to enroll with BlueCross
Facility Information Request	Medical facilities that want to credential with BlueCross
Virtual Care Services	Practitioners or groups that want to render telemedicine and telehealth services
Health Professional	***In-state, out-of-network*** practitioners that want to file claims to BlueCross
Behavioral Health	New practitioners or groups that want to enroll in our behavioral health network
Autism Provider Panel	Applied behavior analysts that want to enroll in our autism provider panel
Satellite Location	***Enrolled groups*** that have ***new locations*** that want to file claims

Forms	Used for…
Doing Business As Name Change	Changing the doing business as (DBA) name of a practice
Change of Address	Updating the physical, pay to, correspondence or billing agency address
NPI Provider Notification	***Out-of-state and out-of-network*** practitioners or groups that need to register their NPI with BlueCross
Add or Terminate Practitioner	Adding or terminating a practitioner's affiliation with a clinic, group or institution

Provider Enrollment Checklists

Individual Enrollment

- Ancillary Providers
- Dental Providers
- Advanced Practice Providers
- Pharmacists
- Physicians and Chiropractors

Group Practice Enrollment

- Ambulance
- Dental
- Durable Medical Equipment
- Home Health, Hospice, etc.
- Pharmacy
- Physician Office

Other

- Behavioral Health
- In State, Out-of-Network
- Out-of-State, Out-of-Network
- Satellite Locations
- Signature Requirements

Providers>Join Our Network

Example of Individual Enrollment Checklist

Checklist Items
Provider Enrollment Application
Copy of SC Medical or Practice License
Drug Enforcement Administration (DEA) Certification*
Current Copy of Malpractice (Min. $1M/$3M)
Authorization to Bill for Services
Signed Contracts
Professional Training**
Hold Harmless***
Appendix D***
Medicaid ID Number****

*Only if applicable.

**Required for MDs, DOs and DPMs.

***Only if applying for BlueChoice HealthPlan.

****Only if applying for Healthy Blue.

Example of Group Enrollment Checklist

Checklist Items
Group Practice Application
IRS Verification of Tax ID (Letter 147C or CP 575 E)
Electronic Funds Transfer
Signed Contracts**
Medicaid ID Number*
Add Practitioner Form***

*Only if applying for Healthy Blue.

**Only for BlueChoice and Healthy Blue. All other commercial contracts are based on the individual practitioner's credentialing status.

For each physician being added to the group. This form does not generate with the group application. It is under the ***Find a Form section of the portal.

Note: If the provider is not credentialed, you must complete the Provider Enrollment application.

Overview of Provider Enrollment Process

- **The provider enrollment team reviews applications to determine if they are clean and completed.**
  - Only clean applications can be sent to the Credentialing Committee for review.
    - Applications that are incomplete or missing items are sent back to the provider and they have ***21 days*** to return the necessary documentation.
    - If the missing items are not received, the application will be canceled on the 28th day.
- **Applications approved by the Credentialing Committee progress through the process and are sent to contracting for review.**
  - Applications that are not approved by the Credentialing Committee are sent to the Disciplinary Committee.
    - The outcome of the review is sent to the provider.
- **Once contracting reviews and executes the contracts, the application is sent to the enrollment team to load the provider into the system.**
  - If contracts are not executed, an explanation is sent to the provider.
- **After the provider is loaded into the system, a welcome email is sent to the provider and includes the network and affiliation dates.**

Things to Note for Provider Enrollment

- **The Credentialing Committee reviews enrollment applications to ensure all required credentialing criteria is met.**
- **Network effective dates are determined by the committee's approval date per the following entity requirements:**
  - Utilizations Review Accreditation Commission (URAC)
  - National Committee for Quality Assurance (NCQA)
  - South Carolina Department of Health and Human Services (SCDHHS), when applicable
- **Network effective dates cannot be backdated.**
  - If contracts are not executed, an explanation is sent to the provider.

Common Missing Items The Delay Enrollment

Unsigned applications or contracts	Invalid dates	Incomplete submissions	Incomplete documentation
• All applications, contracts and required documents must be signed, initialed and dated.	• Malpractice dates must be valid and active on or before the requested start date. • State licenses must be active with current dates. • Signature dates on applications and contracts must be current.	• Licenses, certificates (CLIA, when applicable) and malpractice verification must be included with the application.	• All documents must be filled out in its entirety (i.e., Authorization to Bill for Services).

IMPORTANT NOTE:

An automated notification for missing items is sent every seven days until the information is received. Outreach is made on:

- **Day 7 – First request**
- **Day 14 – Second request**
- **Day 21 – Third (final) request**

If the missing items are not received, the case will be placed in the “Canceled – Incomplete Submission” status.

Recredentialing Process

- **Recredentialing for established providers happens every three years.**
  - Email Recred.App@bcbssc.com if you need to know your upcoming recredentialing date.
    - Include the provider's name and NPI.
- **The credentialing team reaches out when the provider's recredentialing date is approaching.**
  - First, them team calls to see if the provider is actively working at the location we have on file. If so, the application is sent by email or fax.
    - If a response is not received after the first outreach, a second attempt is made in 14 days.
    - If a response is not received after the second outreach, a third attempt is made in seven days.
    - If a response is not received after the third and final outreach, the process to terminate the provider is initiated.
- **If the recredentialing date is missed, the provider is termed, and new enrollment is required.**

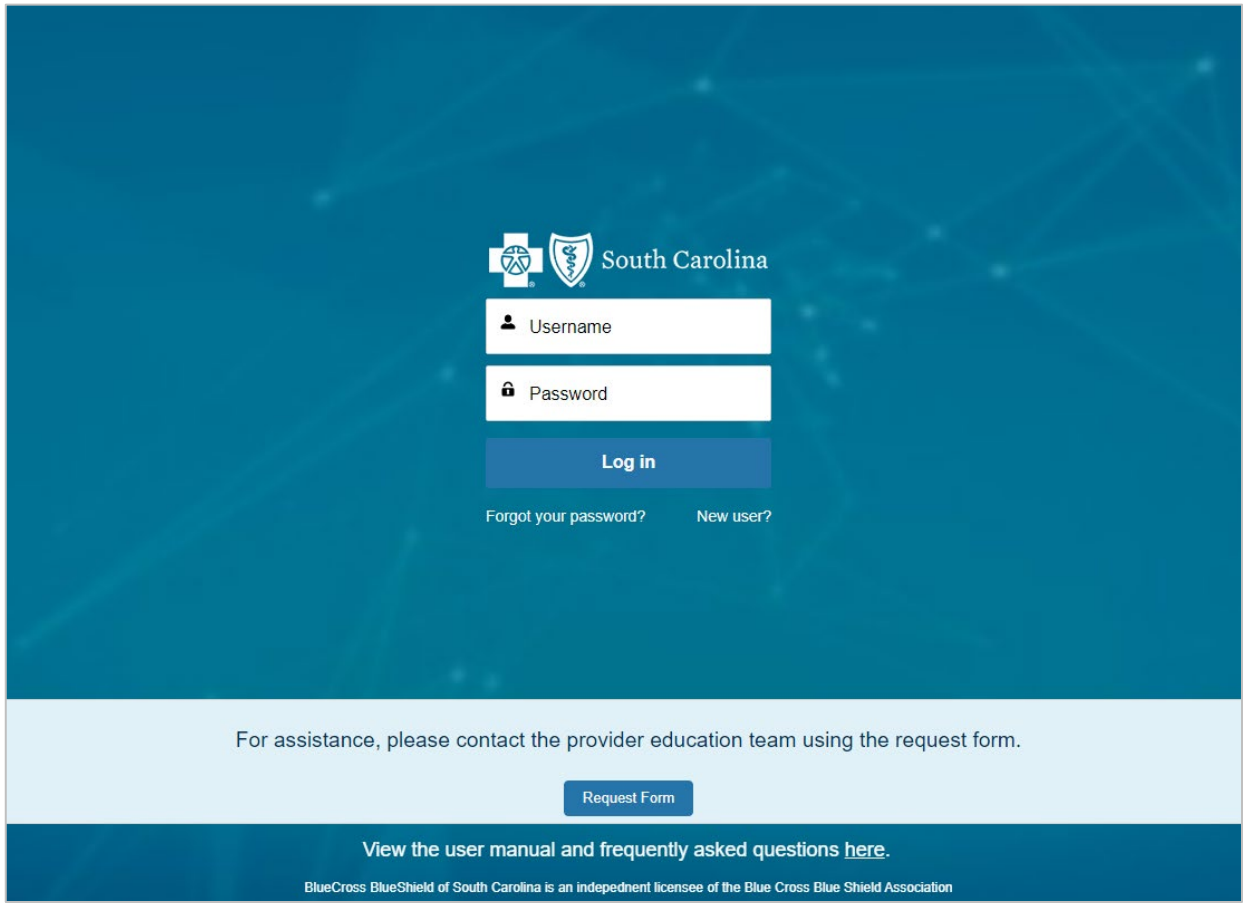
Non-credentialed Providers

- Acupuncturists
- Associate Counselors
- Christian Science Practitioners
- Diabetes Education
- Dieticians*
- Education Specialists
- Homeopaths
- Lay Midwives
- Massage Therapists
- Naturopaths
- Occupational Therapy Assistants
- Physical Therapy Assistants
- Psychology Assistants
- Recreational Therapists
- School Psychologists
- Sports Trainers
- Technicians

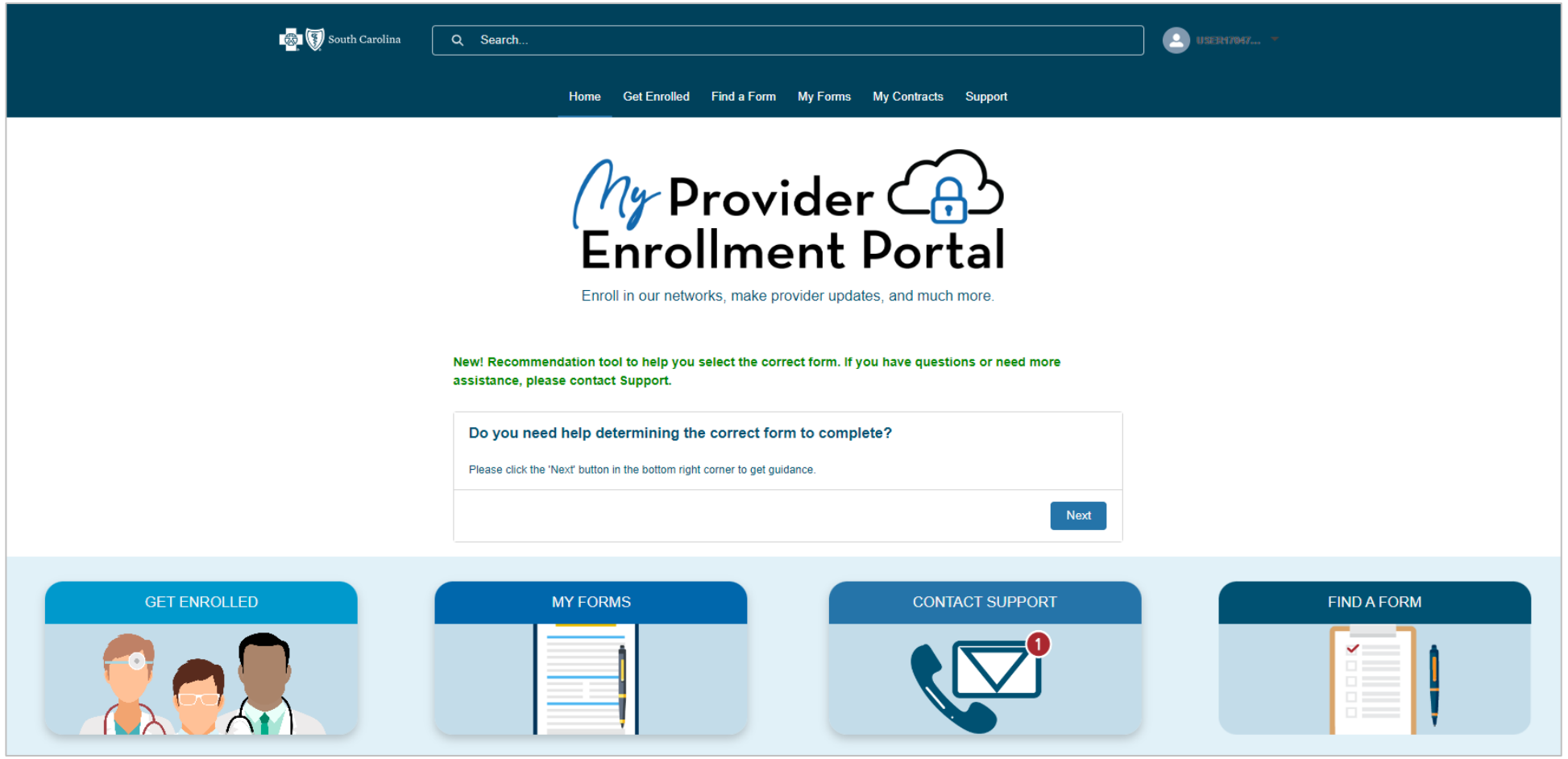
Note: This list may not be all inclusive.
Can join the Healthy Blue network.

How to Join the Healthy Blue Network

- Providers>Join Our Network
- From the My Provider Enrollment Portal landing page, log in using your username and password.
    - If you're new to the portal, select New User.



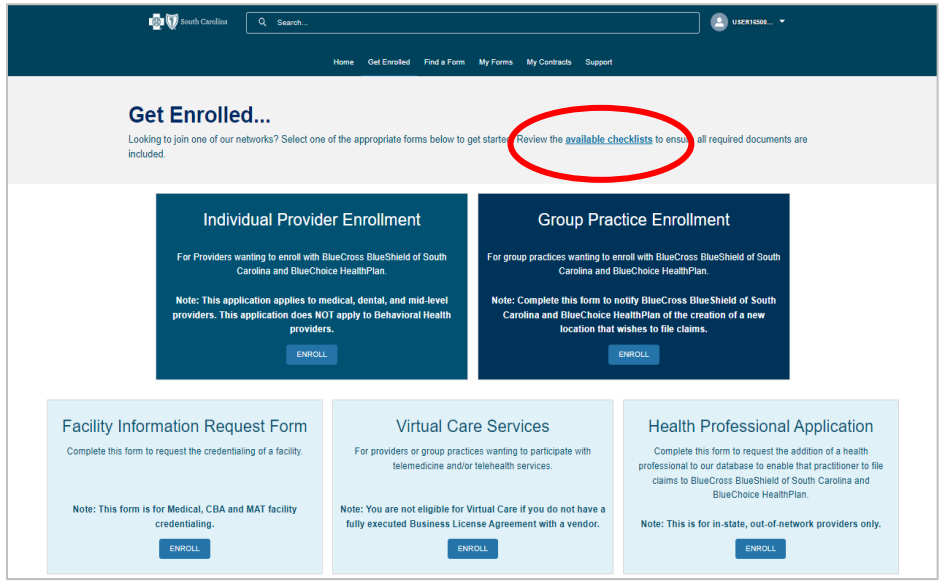
My Provider Enrollment Portal – Home Page

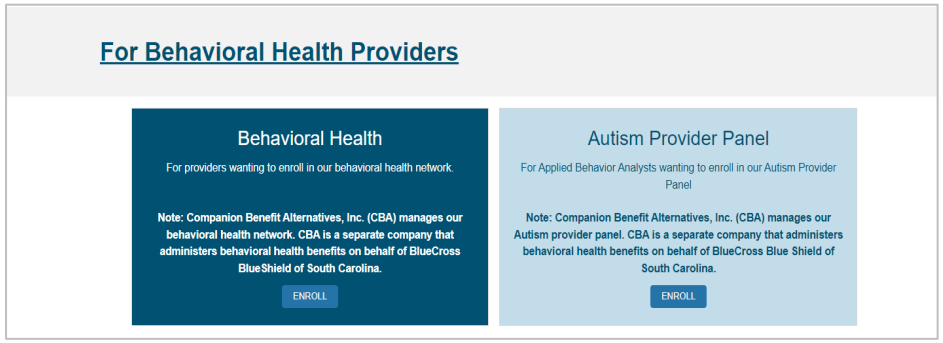


Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

My Provider Enrollment Portal – Get Enrolled





Individual Checklist

Checklist Items	Advanced Practice Provider	Physician	DDS	DMD	Ancillary	Chiro	Pharmacist
Provider Enrollment Application	✓	✓	✓	✓	✓	✓	✓
Copy of SC Medical or Practice License	✓	✓	✓	✓	✓	✓	✓
Drug Enforcement Administration (DEA) Certification*	✓ Footnote 1	✓	✓	✓			✓
Current Copy of Malpractice (Min. $1M/$3M)	✓	✓	✓	✓	✓	✓	✓ Footnote 6
Authorization to Bill for Services	✓	✓	✓	✓	✓	✓	✓
Nurse Practitioner Preceptor Form	✓ Footnote 2						
Protocols (Written Agreement)	✓ Footnote 2						
Signed Contracts	✓	✓	✓ Footnote 4	✓ Footnote 5	✓	✓	✓
Hold Harmless**	✓	✓	✓		✓	✓	✓
Appendix D**	✓	✓	✓		✓	✓	✓
Professional Training***	✓ Footnote 3	✓	✓				
Medicaid ID Number****	✓	✓	✓		✓	✓	✓

*Only if applicable.
**Only if applying for BlueChoice® HealthPlan
***Required for MDs, DOs and DPMs (at minimum, residency.)
****Only if applying for Healthy Blue℠.

[1]Only for NPs, PAs, and Hospitalists.
[2]Only needed for NPs and PAs. needed for hospitalists that are MDs, DOs or DPMs.
[3]Only needed for hospitalists that are MDs, DOs or DPMs.
[4]Medical contract, dental contract, or both.
[5]Dental contract only.
[6]Malpractice coverage for pharmacists is $1M/$1M.

Group Practice Checklist

Checklist Items	Physician Office	Ambulance	DME	Home Health, Hospice, Dialysis, Hospitals, Skilled Nursing, ASC	Pharmacy	Dental
Group Practice Application	✓	✓	✓	✓	✓	✓
IRS Verification of Tax ID (Letter 147C or CP 575E)	✓	✓	✓	✓	✓	✓
Electronic Funds Transfer Enrollment	✓	✓	✓	✓	✓	✓
Signed Contracts	✓	✓	✓	✓	✓	✓ Footnote 2
Copy of CMS Letter		✓	✓ Footnote 1	✓	✓ Footnote 1	
Copy of Business License			✓	✓		
Copy of DHEC License				✓	✓	
Medicaid ID Number*	✓	✓	✓	✓	✓	✓
Copy of NPPES NPI Notification	✓	✓	✓	✓	✓	✓
Add Practitioner Forms**	✓	✓	✓			✓

*Only if applying for Healthy Blue℠.
**For each physician being added to the group. This form does not generate with the group application. It is under the Find a Form section of the portal. Note: If the provider is not credentialed, you must complete the Provider Enrollment application.

[1]CMS letter must include Medicare PTAN.
[2]For oral surgeons applying for BlueChoice and Healthy Blue. All other contracts depend on the individual physician's credentialing status.

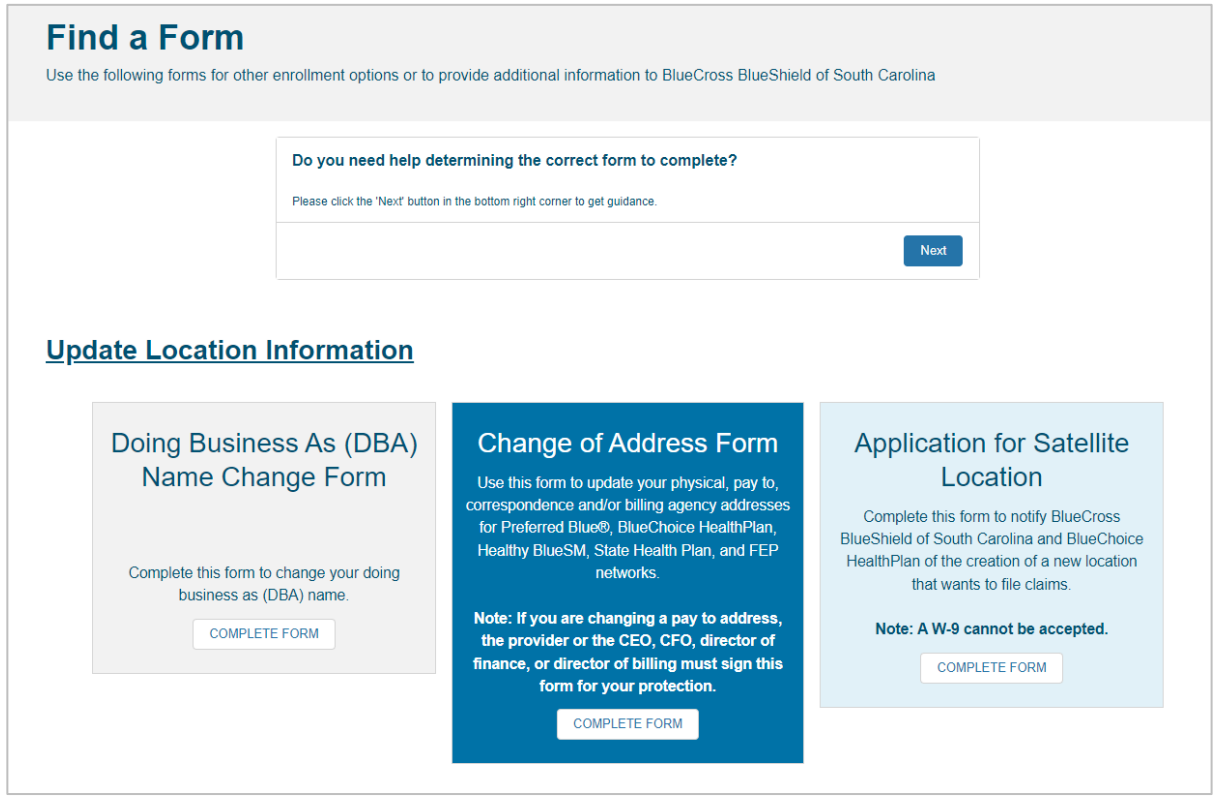
After selecting Enroll for Individual.

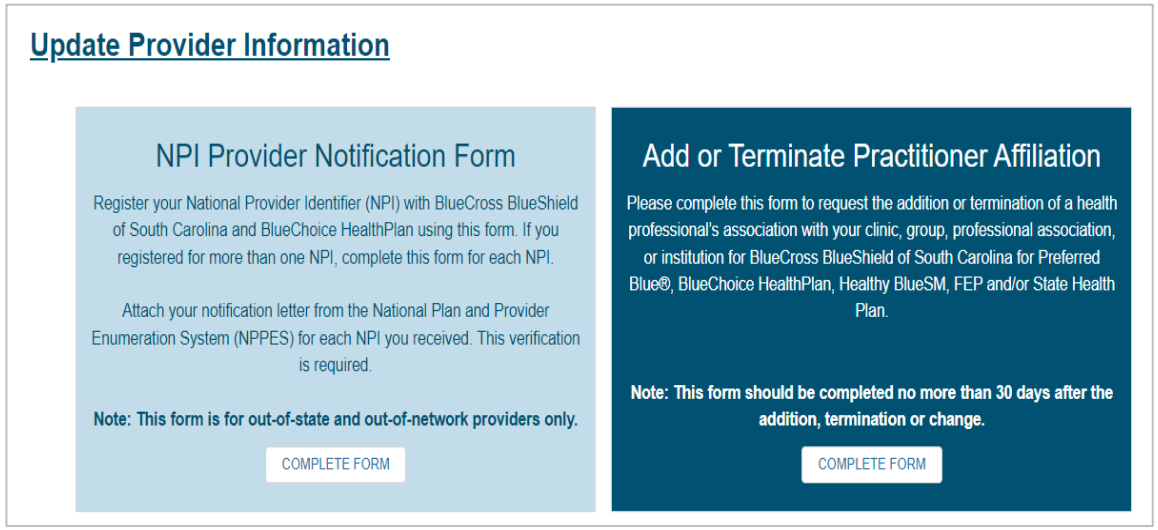
After selecting Enroll for Group Practice.

Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

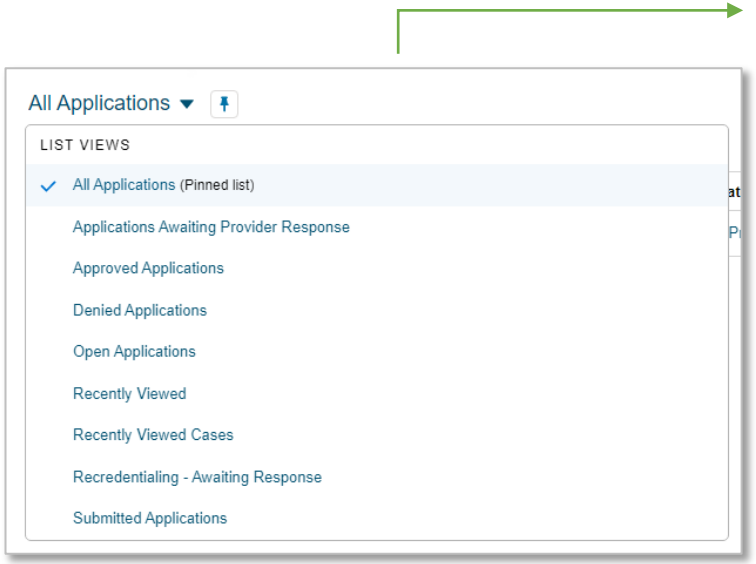
My Provider Enrollment Portal – Find a Form





My Provider Enrollment Portal – My Forms

Available statuses.



My Forms

Complete forms that have been started or check the status of applications already submitted.

- **In Progress/Not Submitted** – The application or form is being worked by the provider or their practice. It has not been completed for submission.
- **Submitted** – The application and **all required documentation with applicable signatures, initials, and dates** have been uploaded.
- **Awaiting Signature/Not Submitted** – The application or form has been completed and submitted, **but signatures are missing.**
- **Awaiting Provider Response** – Missing items are needed from the provider or their practice to continue the enrollment process. You will receive an email and case comment explaining what item(s) is needed.
- **Under Review** – The application or form has been assigned and has progressed through the enrollment process.
- **Congratulations! Complete** – The application or form has been approved and completed.
- **Denied** – The application or form was not approved. An explanation for the denial is sent through email or case comment.
- **Canceled** – The application or form is no longer being worked on and has been closed.

If your case is in the status of Awaiting Signature, click the case number to view next steps.

All Applications

50 items • Sorted by Date/Time Opened • Filtered by All cases

	Case Number	Practitioner Last...	Status	Form Type	Date/Time Opened
1	00022086		In Progress/Not Submitted	Individual Application	4/2/2024, 1:36 PM
2	00022085		In Progress/Not Submitted	NPI Update	4/2/2024, 1:29 PM
3	00022084		In Progress/Not Submitted	NPI Update	4/2/2024, 1:29 PM
4	00022081		In Progress/Not Submitted	Change of Address	4/1/2024, 5:40 PM
5	00022080		In Progress/Not Submitted	Individual Application	4/1/2024, 3:35 PM
6	00022079	Freeman	Awaiting Signature/Not Submitted	Individual Application	4/1/2024, 12:57 PM

My Provider Enrollment Portal – My Contracts

My Contracts

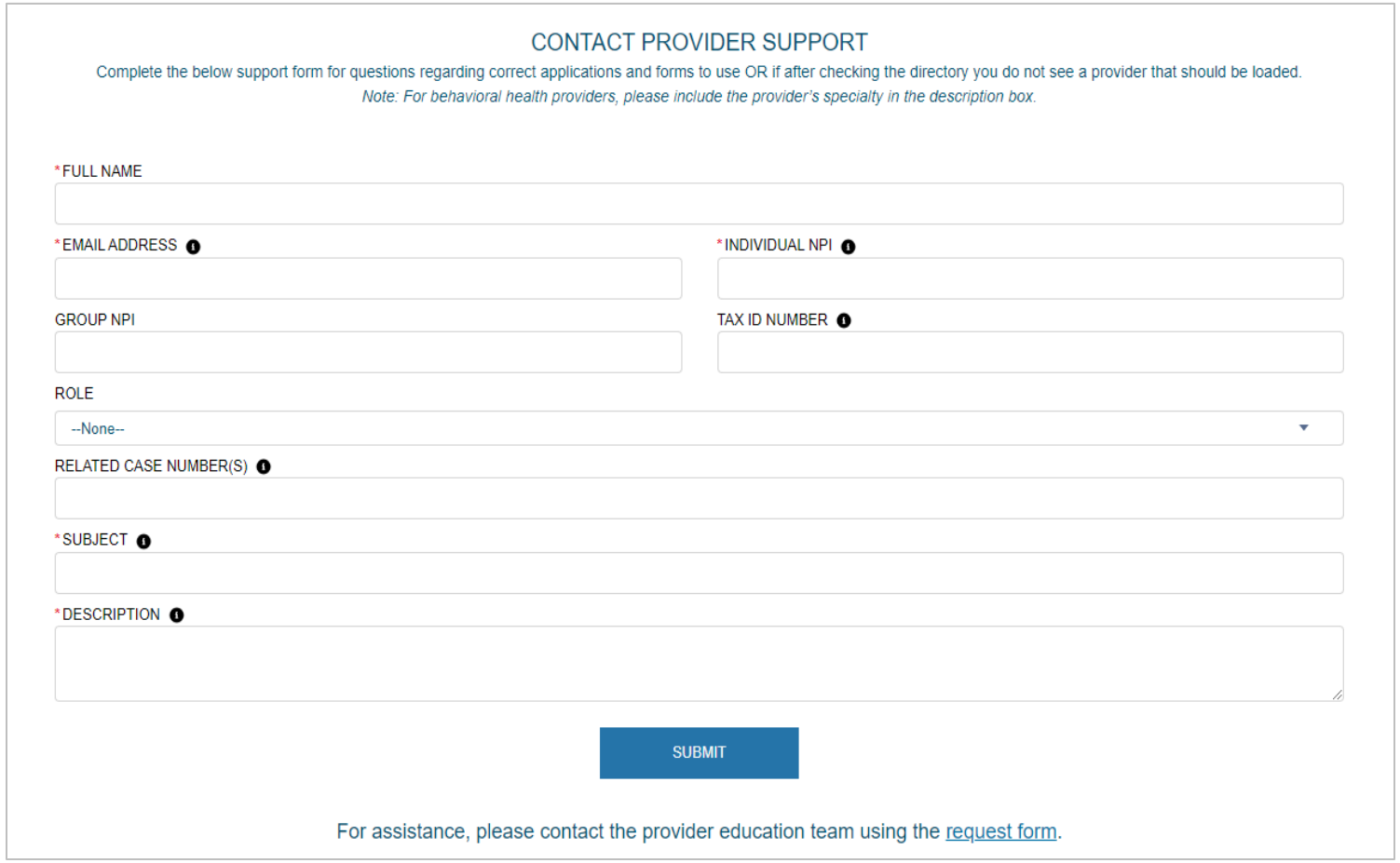
Complete contracts that require your attention or check their status.

All Contracts

4 items • Sorted by Case • Filtered by All form contracts - Status

	Case ↑	Status	Form Contract ...	Network List	Form Type	Last Modified Date
1	00030455	Awaiting Signature	FCR-12433	Blue Essentials	Individual Application	8/4/2023, 7:28 PM
2	00030455	Awaiting Signature	FCR-12434	Medicare Advantage	Individual Application	8/4/2023, 7:28 PM
3	00030455	Awaiting Signature	FCR-12436	State Health Plan	Individual Application	8/4/2023, 7:28 PM
4	00030455	Awaiting Signature	FCR-12435	Preferred Blue® (PPC and FEP)	Individual Application	8/4/2023, 7:28 PM

My Provider Enrollment Portal – Support



My Provider Enrollment Portal – Things to Note

Case Numbers

- Generated with each application, form and support case.

Contracts

- Provided during the application review process and must be included with the application.

Case Comments

- Used for case-specific questions on an application or form.

Statuses

- Used to let you know where the application is in the enrollment process.

Note: You should not manually change your statuses.

My Provider Enrollment Portal – Statuses

In progress/Not submitted	The application or form is being worked by the provider or their practice. It has not been completed for submission.
Submitted	The application and ***all required documentation with applicable signatures, initials and dates*** have been uploaded.
Awaiting signature/Not Submitted	The application or form has been completed and submitted, ***but signatures are missing***.
Awaiting provider response	Missing items are needed to continue the credentialing process.

My Provider Enrollment Portal – Statuses

Under review	The application or form has been assigned and has progressed through the credentialing process.
Congratulations! Complete	The application or form has been approved.
Denied	The application or form was not approved. *Note: Explanation for the denial is sent through email or case comment.*
Canceled	The application or form is no longer being worked and has been closed.

Submitting a Clean Application

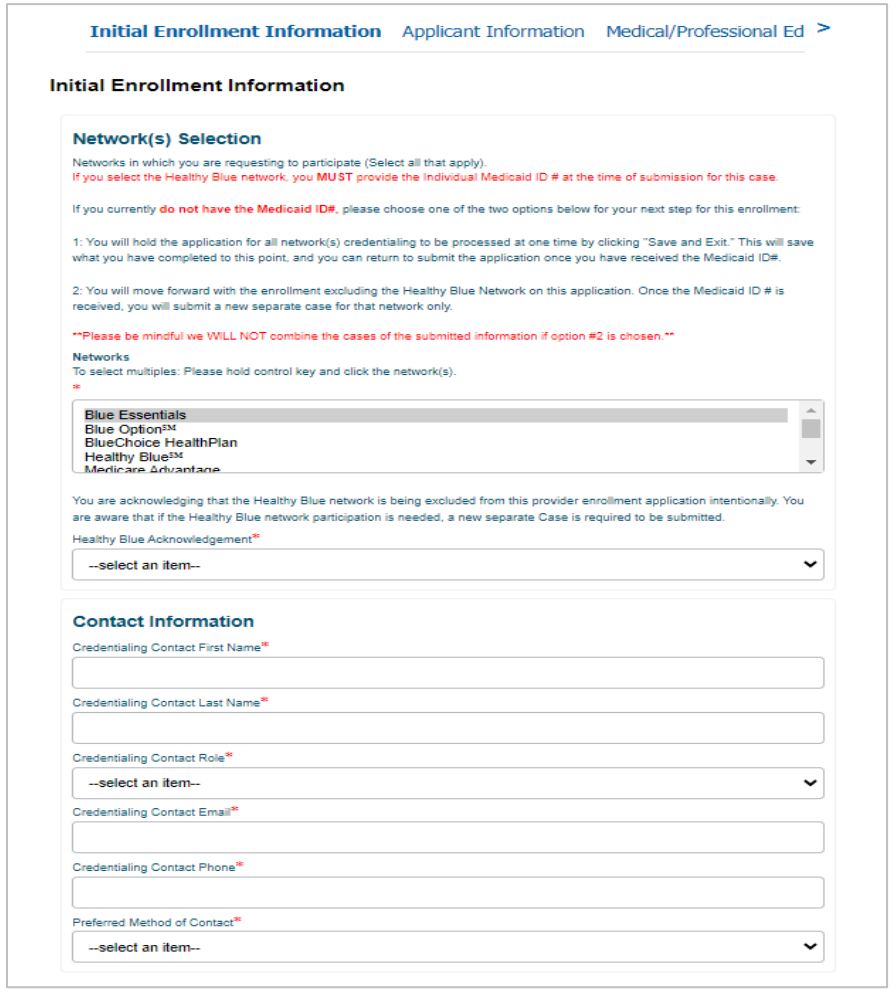
1. **Complete the enrollment application inside the portal.**
2. **Download, print and sign (includes signatures, initials and dates) the application and other applicable documents.**
   - Scan and upload the signed documents, licenses, etc. to the case.
     - Documents are listed under **Form Information**.
3. **Download, print and sign (includes signatures and dates) all applicable contacts.**
   - Scan and upload the signed contracts to the case.
     - Contracts are listed on the home page of the portal, or you can go to **My Contracts**.

Note: Medical contractual pages must be signed in ink. All behavioral health documents can be signed in ink or electronically.

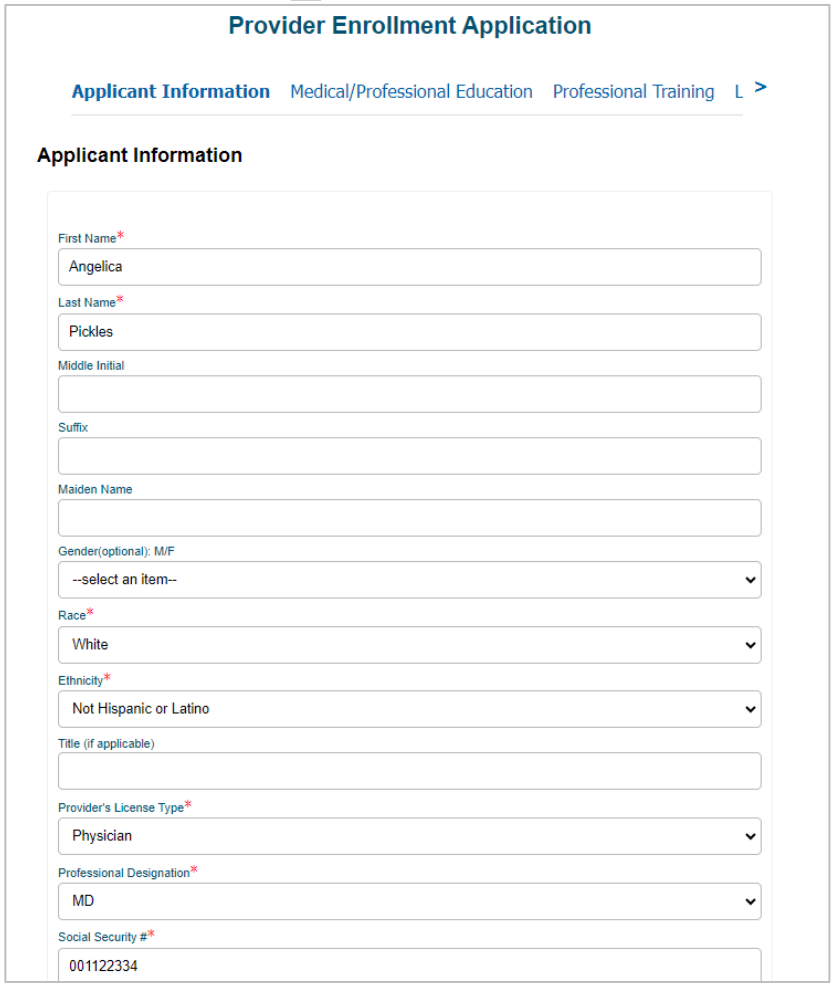
Example of Individual Enrollment

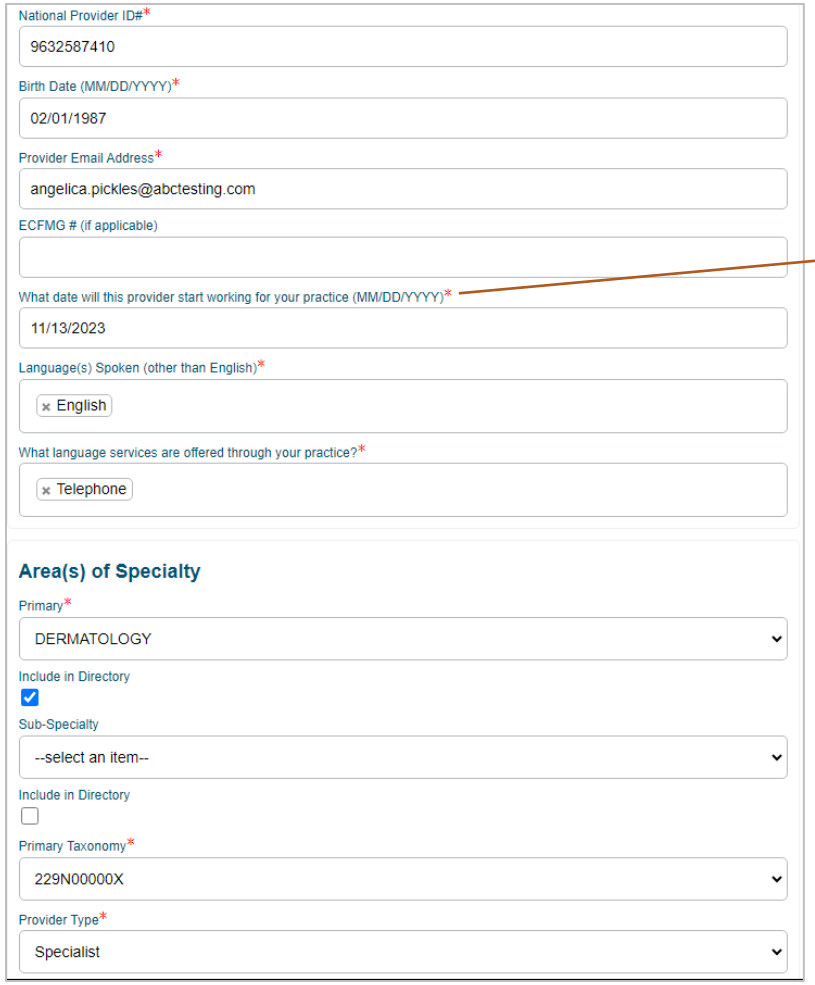
Checklist Items
Provider Enrollment Application
Copy of SC Medical or Practice License
Drug Enforcement Administration (DEA) Certification*
Current Copy of Malpractice (Min. $1M/$3M)
Authorization to Bill for Services
Signed Contracts
Professional Training**
Hold Harmless***
Appendix D***
Medicaid ID Number****

Start with the appropriate checklist.



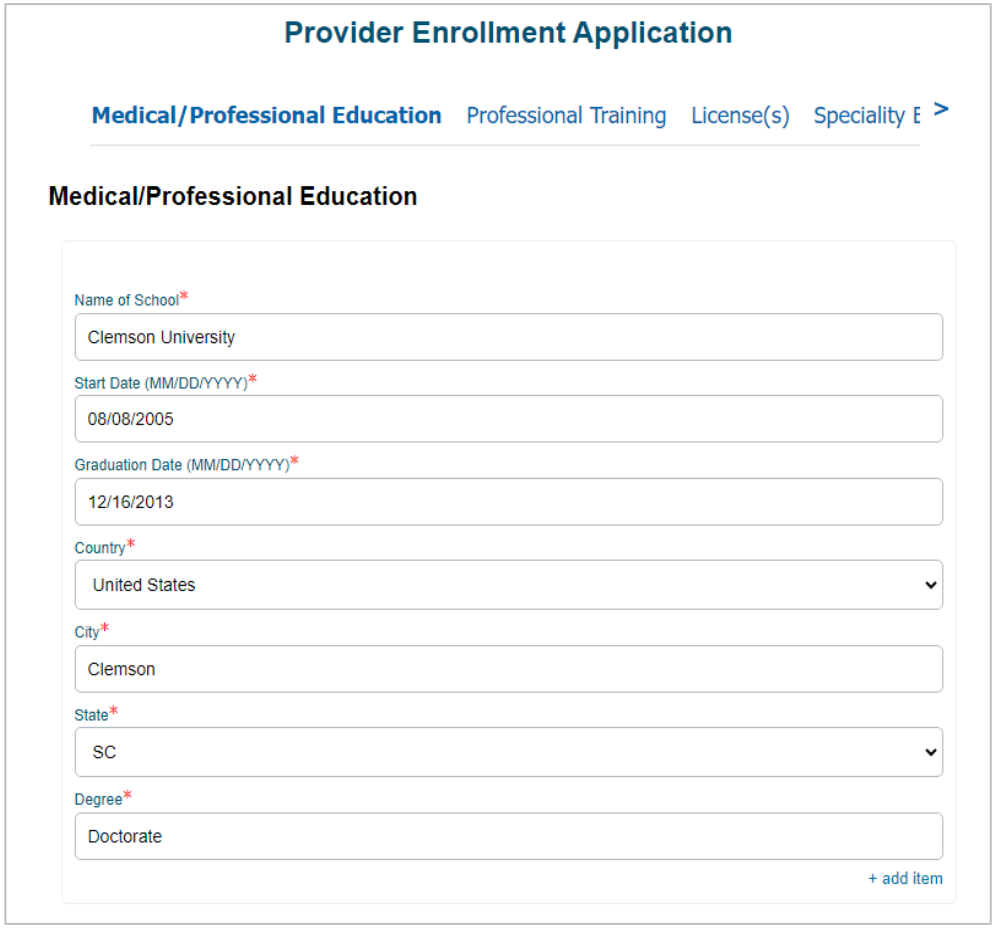
Example of Individual Enrollment (Continued)



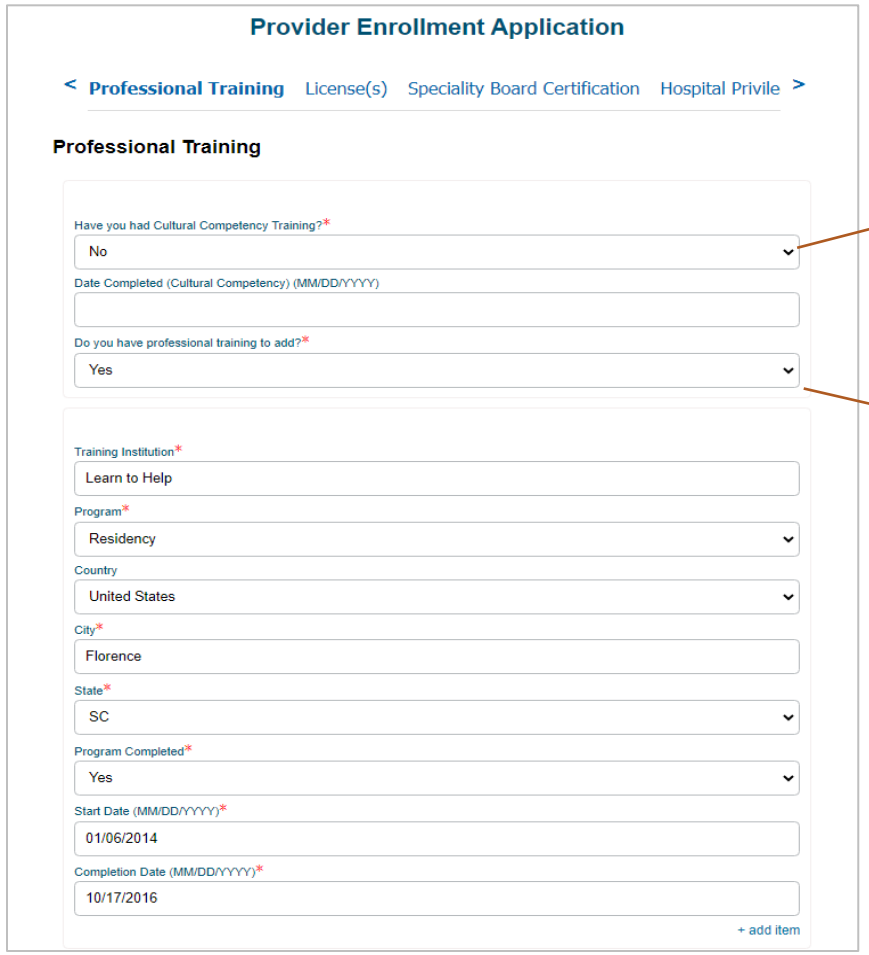


Must match the current work history and authorization to bill.

Example of Individual Enrollment (Continued)



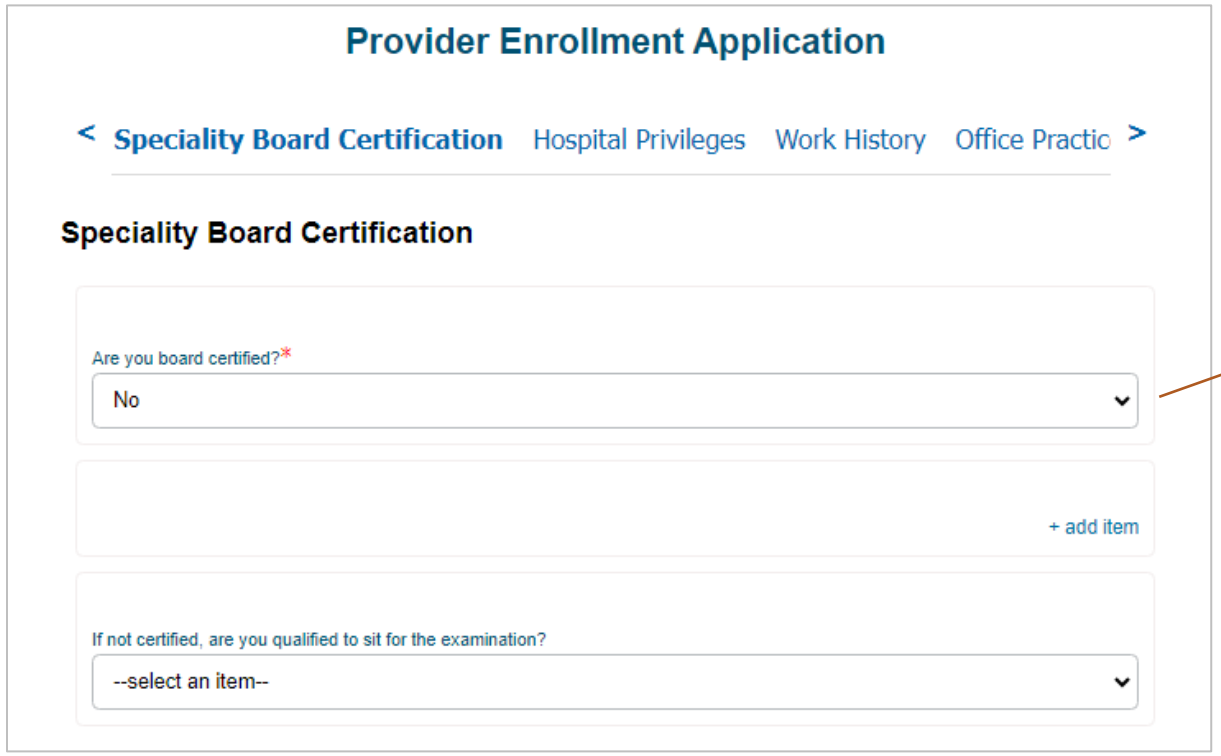
Example of Individual Enrollment (Continued)



Cultural Competency is required for Healthy Blue

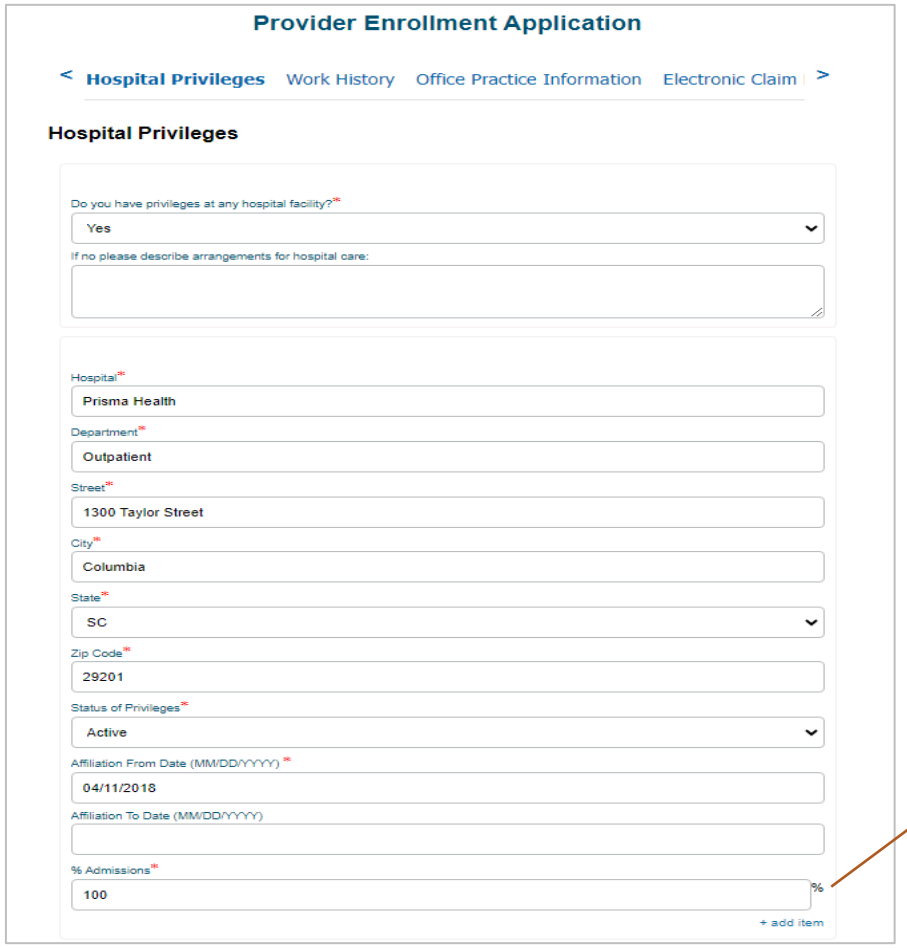
DOs, DPMs and MDs must have a minimum of residency training for credentialing.

Example of Individual Enrollment (Continued)



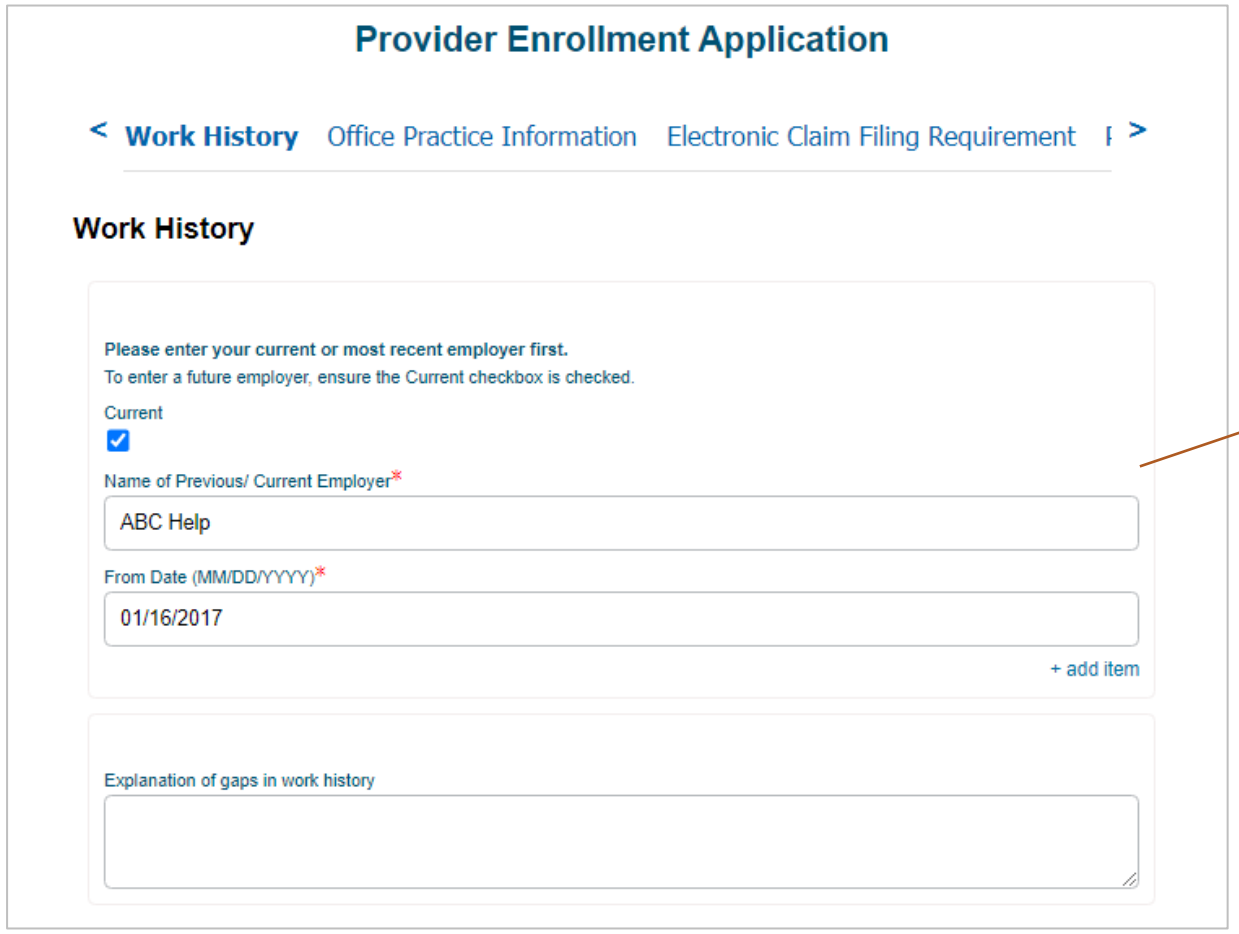
If you select Yes, additional details are required.

Example of Individual Enrollment (Continued)



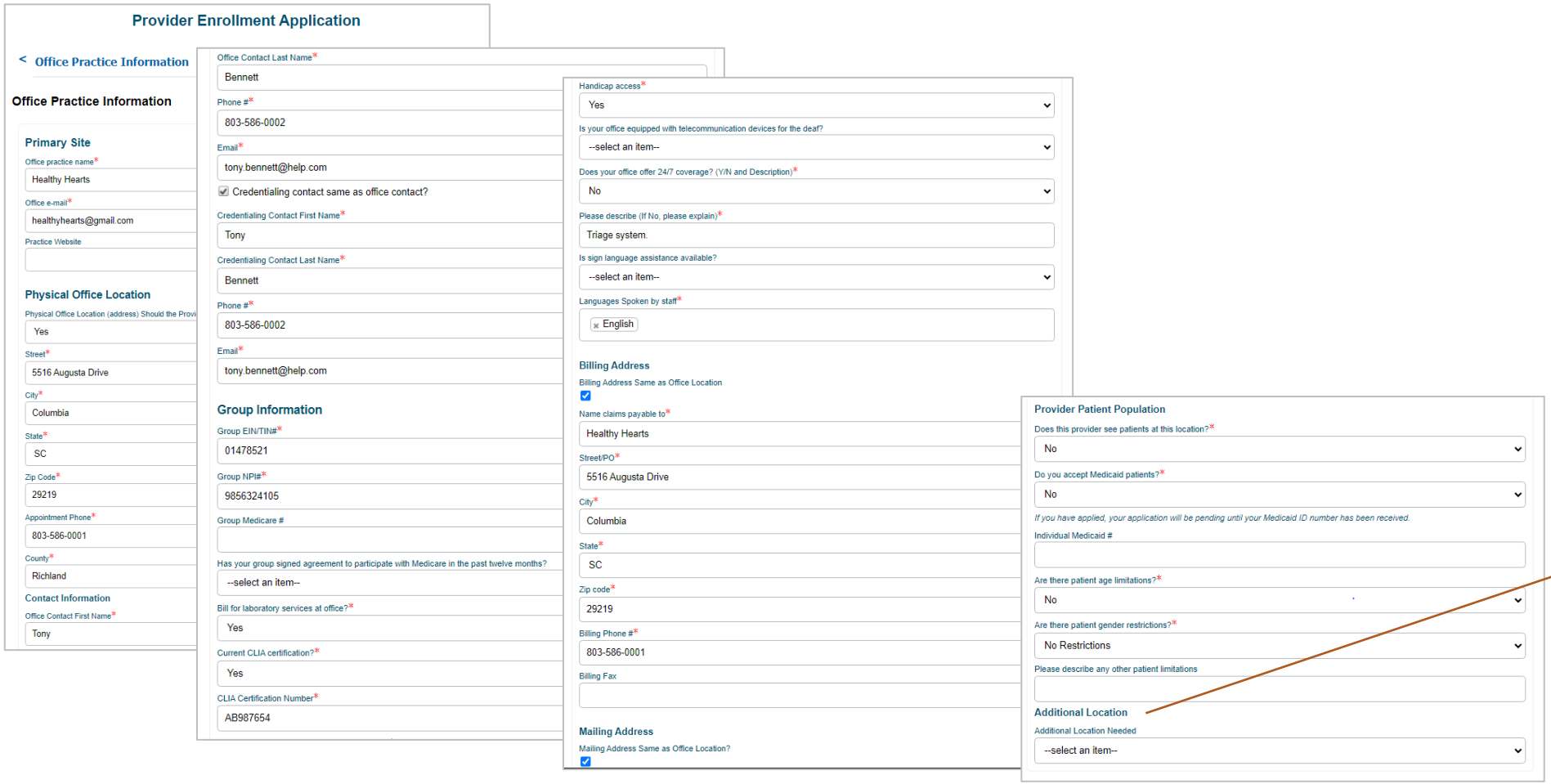
Admissions must total 100%. If there are multiple privileges, the <u>TOTAL</u> should be 100 combined, not separately.

Example of Individual Enrollment (Continued)



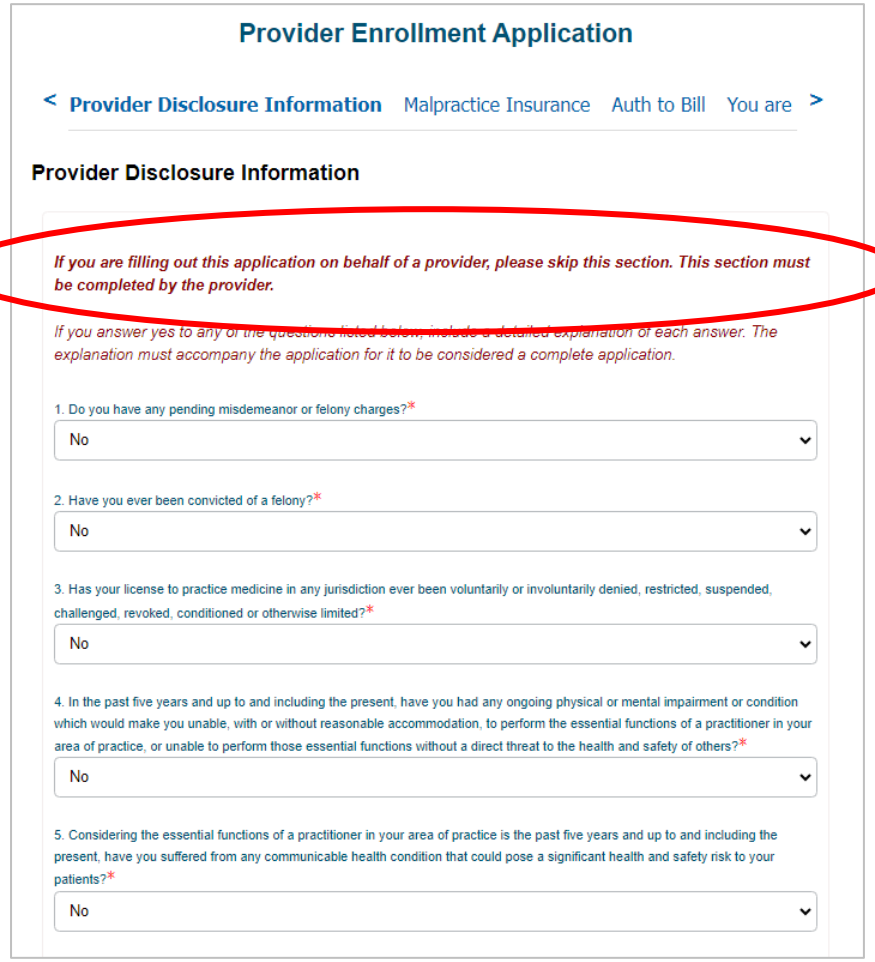
Be sure to select the 'Current' box if the provider is currently working for the practice. Additionally, if their work history does not cover five years, please include an explanation.

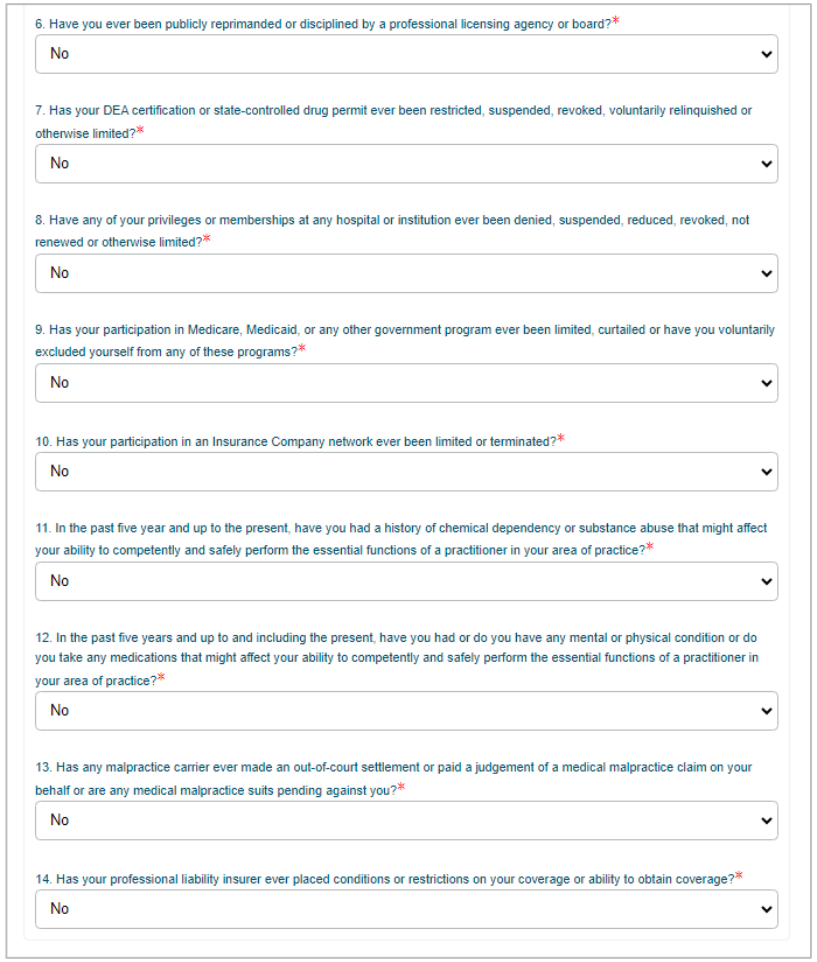
Example of Individual Enrollment (Continued)



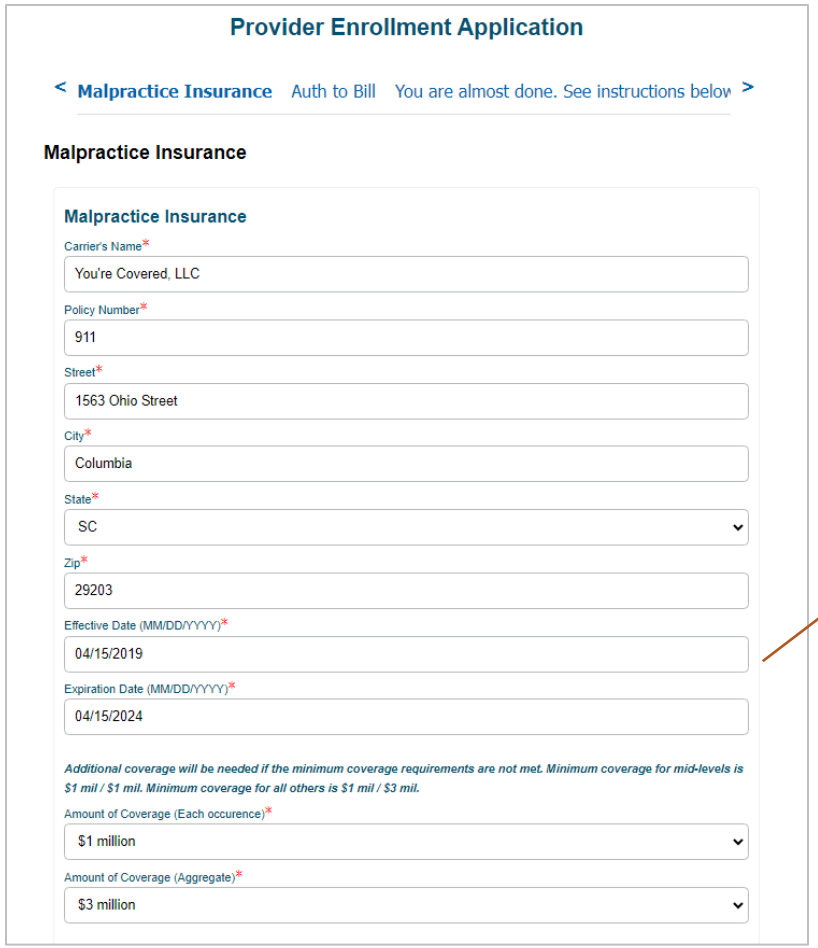
Only the primary and secondary locations can be added in the portal.

Example of Individual Enrollment (Continued)

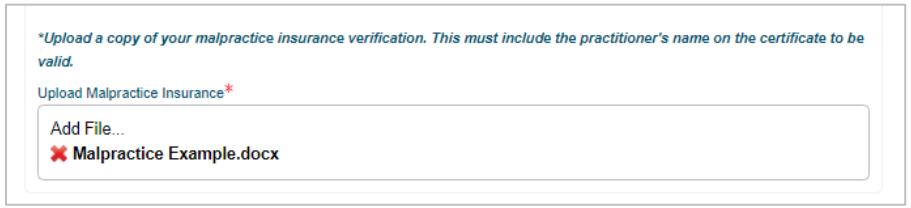




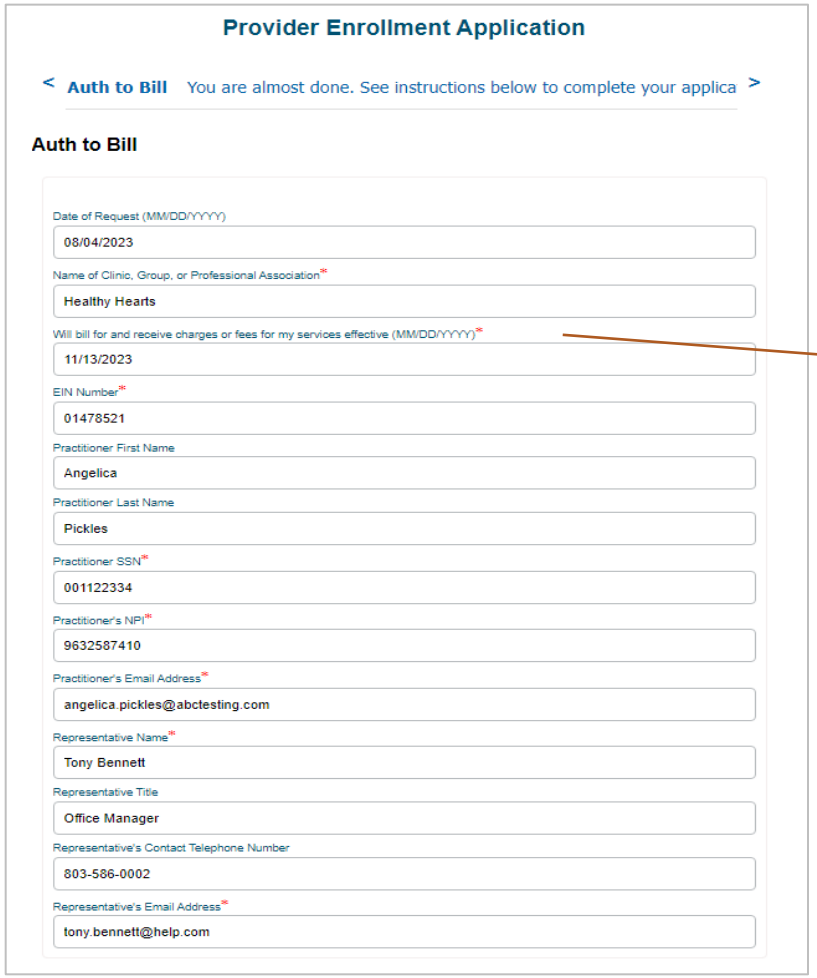
Example of Individual Enrollment (Continued)



Malpractice must be active on or before the requested start date for the practice.



Example of Individual Enrollment (Continued)



Provider Enrollment Application

< Auth to Bill You are almost done. See instructions below to complete your applica >

Auth to Bill

Date of Request (MM/DD/YYYY)
08/04/2023

Name of Clinic, Group, or Professional Association*
Healthy Hearts

Will bill for and receive charges or fees for my services effective (MM/DD/YYYY)*
11/13/2023

EIN Number*
01478521

Practitioner First Name
Angelica

Practitioner Last Name
Pickles

Practitioner SSN*
001122334

Practitioner's NPI*
9632587410

Practitioner's Email Address*
angelica.pickles@abctesting.com

Representative Name*
Tony Bennett

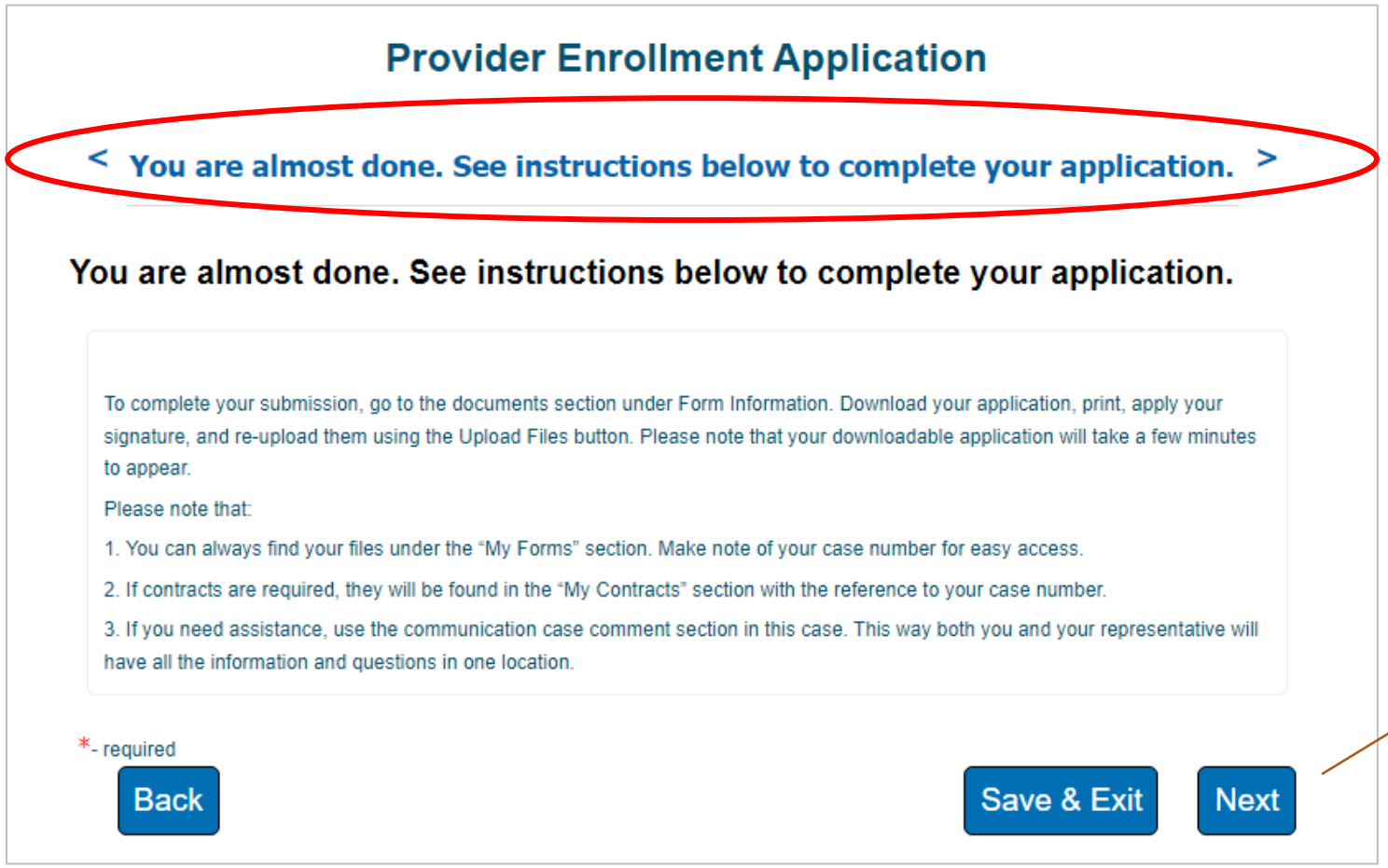
Representative Title
Office Manager

Representative's Contact Telephone Number
803-586-0002

Representative's Email Address*
tony.bennett@help.com

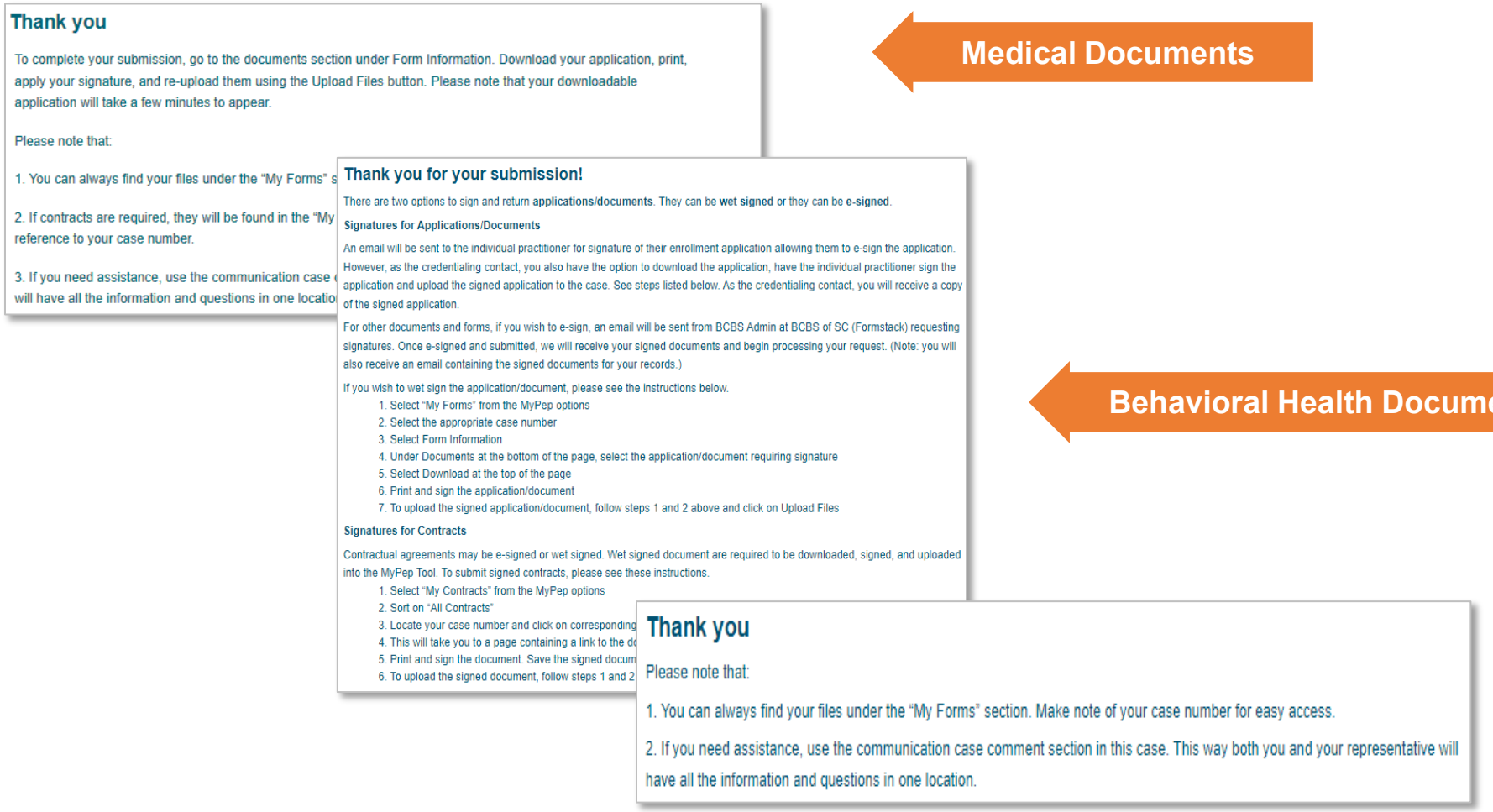
Must match the requested start date with the practice on page one of the application. Must also match the current work history date.

Example of Individual Enrollment (Continued)



Be sure to select Next to complete the application.

Example of Individual Enrollment (Continued)



Thank you

To complete your submission, go to the documents section under Form Information. Download your application, print, apply your signature, and re-upload them using the Upload Files button. Please note that your downloadable application will take a few minutes to appear.

Please note that:

1. You can always find your files under the "My Forms" s

2. If contracts are required, they will be found in the "My reference to your case number.

3. If you need assistance, use the communication case will have all the information and questions in one locatio

Thank you for your submission!

There are two options to sign and return **applications/documents**. They can be **wet signed** or they can be **e-signed**.

Signatures for Applications/Documents

An email will be sent to the individual practitioner for signature of their enrollment application allowing them to e-sign the application. However, as the credentialing contact, you also have the option to download the application, have the individual practitioner sign the application and upload the signed application to the case. See steps listed below. As the credentialing contact, you will receive a copy of the signed application.

For other documents and forms, if you wish to e-sign, an email will be sent from BCBS Admin at BCBS of SC (Formstack) requesting signatures. Once e-signed and submitted, we will receive your signed documents and begin processing your request. (Note: you will also receive an email containing the signed documents for your records.)

If you wish to wet sign the application/document, please see the instructions below.

1. Select "My Forms" from the MyPep options
2. Select the appropriate case number
3. Select Form Information
4. Under Documents at the bottom of the page, select the application/document requiring signature
5. Select Download at the top of the page
6. Print and sign the application/document
7. To upload the signed application/document, follow steps 1 and 2 above and click on Upload Files

Signatures for Contracts

Contractual agreements may be e-signed or wet signed. Wet signed document are required to be downloaded, signed, and uploaded into the MyPep Tool. To submit signed contracts, please see these instructions.

1. Select "My Contracts" from the MyPep options
2. Sort on "All Contracts"
3. Locate your case number and click on corresponding
4. This will take you to a page containing a link to the d
5. Print and sign the document. Save the signed docum
6. To upload the signed document, follow steps 1 and 2

Thank you

Please note that:

1. You can always find your files under the "My Forms" section. Make note of your case number for easy access.

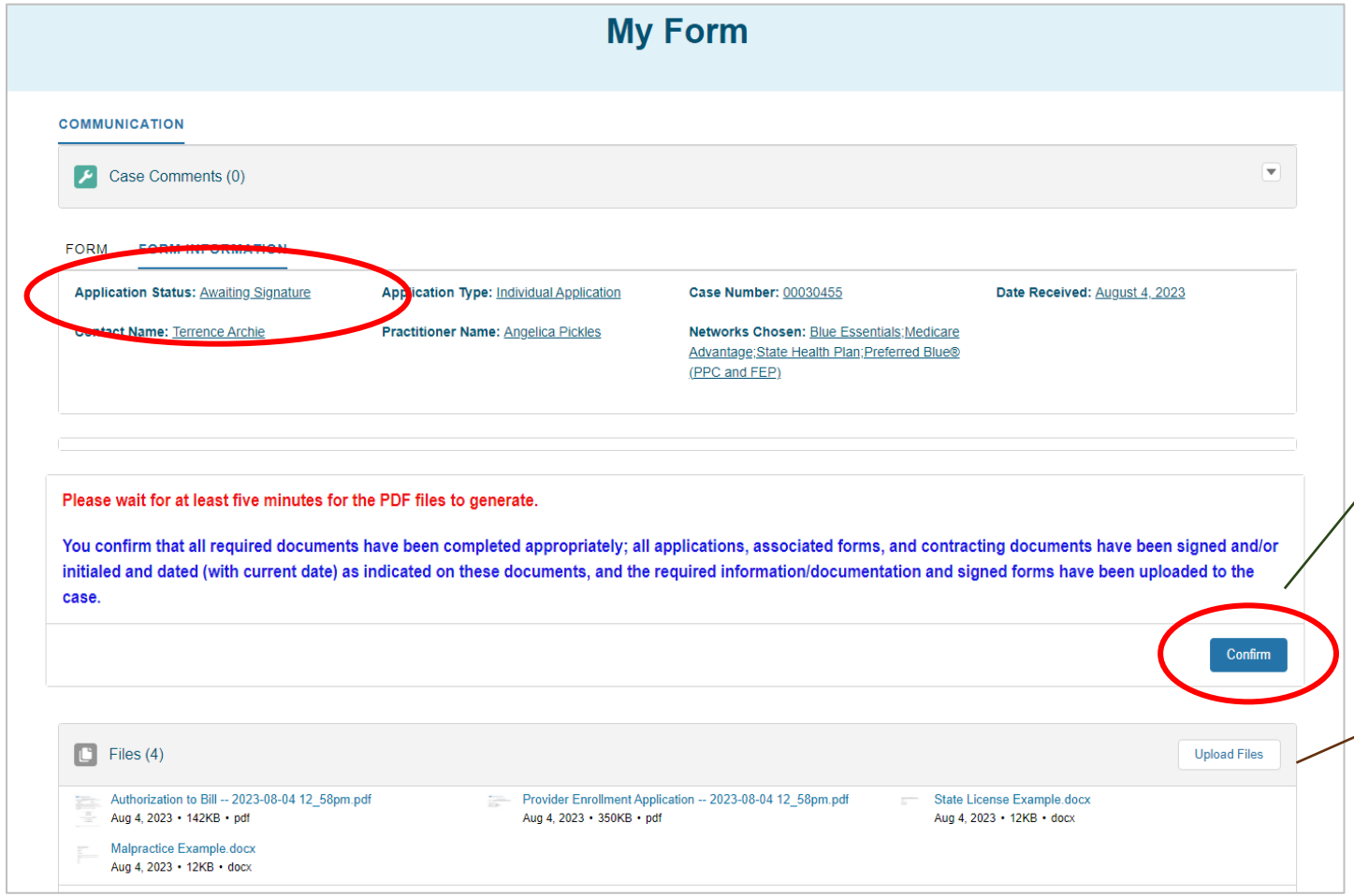
2. If you need assistance, use the communication case comment section in this case. This way both you and your representative will have all the information and questions in one location.

Medical Documents

Behavioral Health Documents

No Signature

Example of Individual Enrollment (Continued)



Only select this button *AFTER* the documents have generated and all required items have been uploaded.

If some of your files do not generate, Select Upload Files to add any missing documents.

Example of Individual Enrollment (Continued)

FORM **FORM INFORMATION**

Application Status: Submitted

Application Type: Individual Application

Case Number: 00030455

Date Received: August 4, 2023

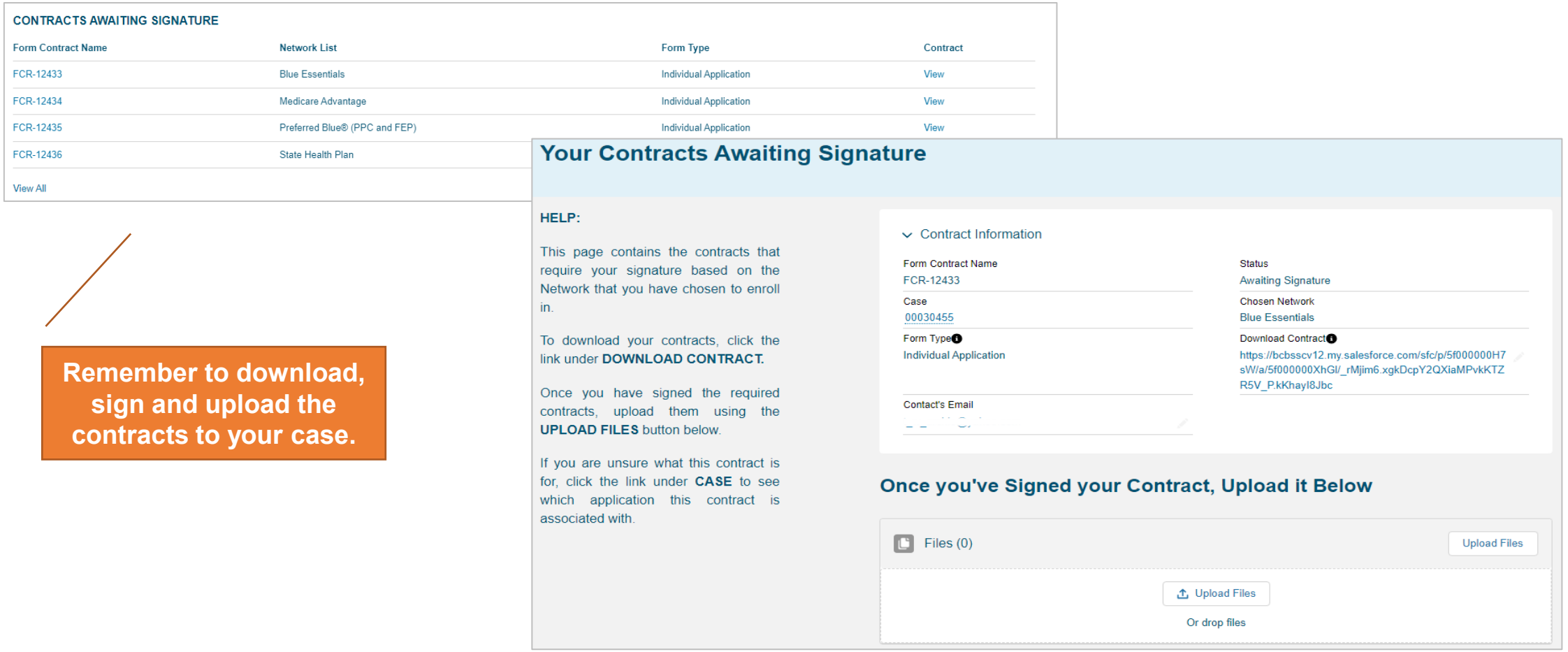
Contact Name: Terrence Archie

Practitioner Name: Angelica Pickles

Networks Chosen: Blue Essentials;Medicare Advantage;State Health Plan;Preferred Blue® (PPC and FEP)

Thank you for uploading your documents.

Example of Individual Enrollment (Continued)



Remember to download, sign and upload the contracts to your case.

Making Corrections to Applications

- **All corrections must be made in the portal.**
  - Allows the system to track the corrections and applies them to the appropriate fields.
  - The newly system generated document will include the corrections and must be printed, signed, dated and initialed (if applicable).
- **Handwritten or other altered corrections are not accepted and will be returned.**

Steps to Making Corrections to Applications

Below is the information we are missing:

Here are your next steps:

1. If you are **ONLY** correcting information in the application:

- **CLICK** the Form tab to make your corrections in the application.
- **CLICK** the **NEXT** button at the bottom of each section.
- **AFTER** clicking the last **NEXT** button, **WAIT** until the new forms generate
- **DOWNLOAD** the updated PDFs to have them signed.

2. If you are **ONLY** uploading files and **DID NOT** correct any information in the application:

- **UPLOAD** your files **FIRST.**
- **CLICK** the **CONFIRM** button below the Documents section.

3. If you are correcting information in the application **AND** uploading files:

- **CORRECT** the information in the form like in Step 1 **FIRST.**
- **UPLOAD** the applicable files after the new PDFs are generated like in Step 2.
- **AFTER** your signed documents have been uploaded, click the **CONFIRM** button below the Documents section.

Available Provider Enrollment Resources

My Provider Enrollment Portal Manual

Provider Enrollment Presentation

Provider Enrollment FAQs

Quality

Quality Contacts

HEDIS® and Care Opportunity	Healthy Blue Quality Manager	Quality Navigators	Medical Records Submission
Luna Lugo-Latorre	Christal McCall	Fax: 803-419-8191	Fax: 803-419-8191
Luna.Lugo@bcbssc.com	Christal.McCall@healthybluesc.com	Navigator@bcbssc.com	HEDIS.RECORDS@bcbssc.com

Healthcare Effectiveness Data and Information Set (HEDIS) is a registered trademark of the National Committee for Quality Assurance (NCQA).

National Committee for Quality Assurance

Contracts

Bonuses and Incentives

Reporting

Reporting Data performed back to the plan

Safety

Measures the plan's consistency in providing recommended care

NCQA and CAHPS*

Consumer Satisfaction

Assesses patient's feedback ranking the health plan

Prevention

Gauges patient's ranking of annual visits, vaccines, etc.

Treatment

Measures the plan's consistency in providing recommended care

Standards & Guidelines + **Quality Measures** + **Member Experience**

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CAHPS

Opportunities	Possible Solutions
Q22 – Rating of Specialist seen most often	❑ Listen to patient concerns and spend adequate time with them ❑ Engage the patient in discussions about medications ❑ Avoid using medical jargon and technical language
Q24 – Customer Service provided need information or help	❑ Ensure that representative are friendly and polite ❑ Resolve issues completely and follow up with members ❑ Ensure that representatives listen carefully and avoid interrupting
Q18 – Rating of personal doctor	❑ Ensure that providers are informed about the patient's relevant medical and person background ❑ Remain up-to-date on medical advancements ❑ Connect with the patient on a personal level ❑ Reduce wait times in the office
Q9 – Ease of getting care, tests, or treatment	❑ Conduct a thorough assessment of the patient's needs ❑ Treat patients with urgent issues promptly ❑ Provider care and service quickly ❑ Minimize wait times and communicate reasons for delays
Q5 – Made appointments for routine care at office or clinic	❑ Schedule appointments within sufficient time frame ❑ Treat patients with great urgent issues promptly
Q4 – Got an appointment for urgent care as soon as needed	❑ Schedule appointments within sufficient time frame ❑ Treat patients with great urgent issues promptly

HEDIS

Evaluates performance in terms of clinical quality

Administered by NCQA and used by CMS* for monitoring

HEDIS Retrospective reviews care given or due in the prior year

HEDIS Prospective is referred to Year-Round HEDIS, which continuously monitors rates in real time

Centers for Medicare & Medicaid Services

HEDIS: How to Close Care Gaps

- Claims Submission
- Remote Access (to EMR)
- Data Transfers
- Medical Records

HEDIS Measures – Prevention and Treatment

Well Care for Children

- **WCC -** Weight Assessment and Counseling for Nutrition and Physical Activity
  - 3-17 years of age
- **W30**
  - 0-15 months (6 visits)
  - 16-30 months (2 visits)
- **WCV**
  - 3-21 years of age; one visit per year
- **CIS -** Childhood Immunization Status
  - Immunizations given by the 2nd birthday
- **IMA -** Immunizations for Adolescents
  - Immunizations given by the 13th birthday
- **Lead Screening**
  - Completed on or by the 2nd birthday

Diabetic Care

- **GSD -** Glycemic Status Assessment for Patients with Diabetes
- **EED -** Eye Exam for Patients with Diabetes
- **BPD -** Blood Pressure Control for Patients with Diabetes
- **KED -** Kidney Health Evaluation for Patients with Diabetes
  - One eGFR (Estimated Glomerular Filtration Rate Lab Test and
  - One uACR (Urine Albumin-Creatinine Ratio)

  or
  - One eGFR with **BOTH** a Quantitative urine albumin test **AND** a Urine creatinine test

Women's Health

- **PPC -** Prenatal and Postpartum Care
- **CHL -** Chlamydia screening
- **BCS -** Breast and cervical cancer screening
- **CCS -** Cervical Cancer screening

Behavioral Health

- **AMM -** Antidepressant Medication Management
- **ADD -** Follow-Up for Children Prescribed ADHD Medication
- **FUH -** Follow-Up After Hospitalization for Mental Illness
- **FUM -** Follow-Up after Emergency Department Visit for Mental Illness
- **FUA -** Follow-Up after Emergency Department Visit for Substance Use
- **APP -** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- **APM -** Metabolic Monitoring for Children and Adolescents on Antipsychotics
- **IET -** Initiation & Engagement of Alcohol and Other Drug Dependence Treatment

HEDIS Measures – 2024 Incentives

Well-Child Visits

- Providers can receive the $60 incentive for each Healthy Blue child that receives a well-child visit.
- Age group for incentives:
  - **0 to 15 months of age** in MY2024
  - **3 to 6 years of age** in MY2024
  - **12 to 20 years of age** in MY2024

CPT Category II Codes

- Providers can receive $40 for CPT Category II code submissions.
- CPT II codes must be submitted with the following:
  - Appropriate office date
  - Appropriate diagnosis code
- Payments are made once per service, per member and per year

Sports Physicals

- Providers can receive $30 for performing a sports physical.
- Only for members 6 to 18 years of age.
- If the member has not had their well-child visit for the year, you can bill for the well-child and sports physical on the same claim.

Note: Visit the Healthy Blue website for more information on each incentive.

Quality Navigator Program

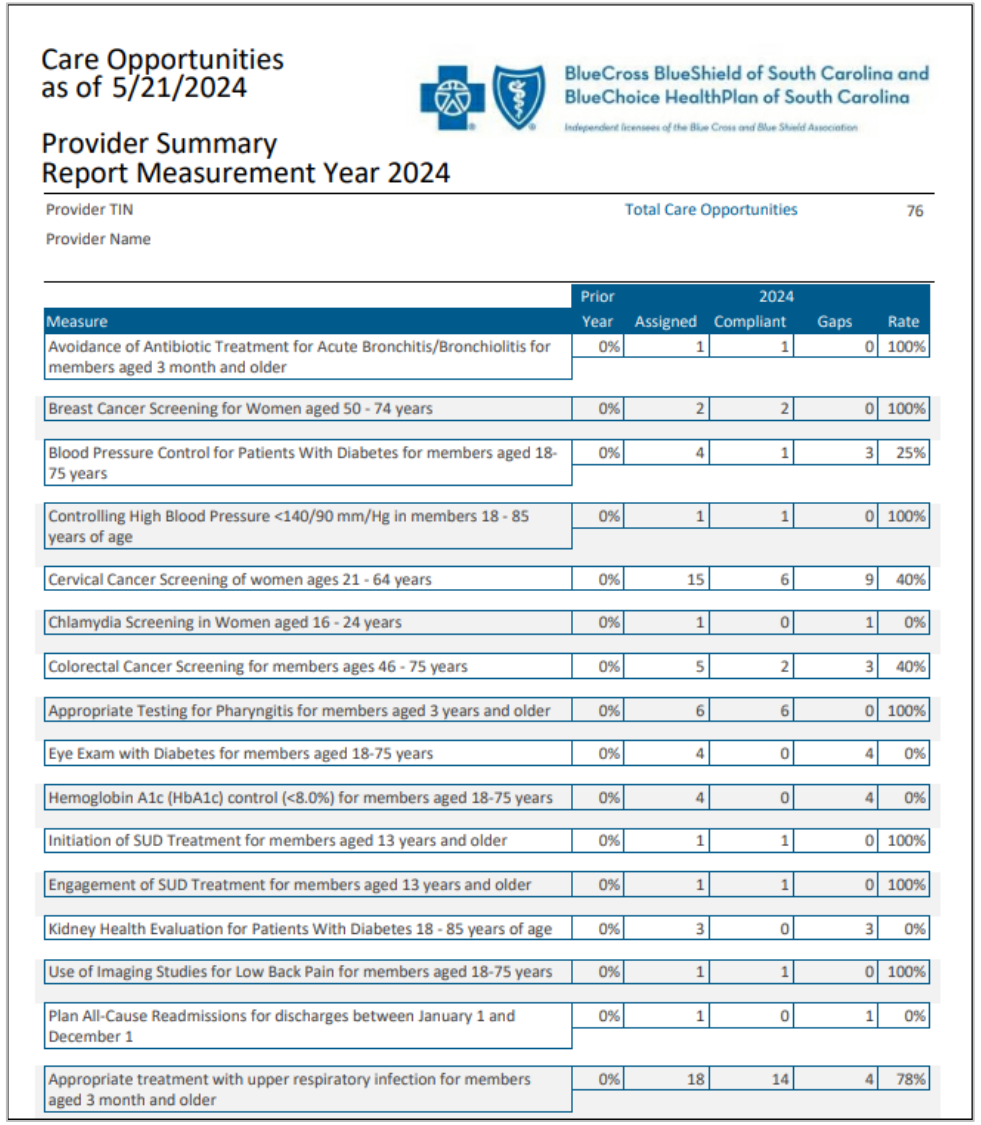
Quality Navigator Model

- The quality navigator model is a population health and quality improvement program designed to assist primary care physicians (PCPs) in meeting quality metrics. We currently have 13 Quality Navigators.
- The goal of the program is to assist PCPs by:
  - Streamline care coordination.
  - Providing help tools and resources to support patient care efforts.
- Benefits include:
  - Promotes accurate coding guidance.
  - Facilitates referrals to disease and case management programs to support treatment plans.
  - Assists with care coordination.

Care Opportunity Reports

Care opportunity reports include the following details and are available in My Insurance Manager.

- Total care opportunities in the eligible population.
- Number of target members needed to be seen to meet the NCQA percentile.
- Members who have not had any visits in the prior year.
- Members who need preventive services.
- Legend for each measure on the Care Opportunity report.



Care Opportunities
as of 5/21/2024

BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina
Independent licensees of the Blue Cross and Blue Shield Association

Provider Summary
Report Measurement Year 2024

Provider TIN
Provider Name

Total Care Opportunities 76

Measure	Prior Year	2024 Assigned	Compliant	Gaps	Rate
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis for members aged 3 month and older	0%	1	1	0	100%
Breast Cancer Screening for Women aged 50 - 74 years	0%	2	2	0	100%
Blood Pressure Control for Patients With Diabetes for members aged 18-75 years	0%	4	1	3	25%
Controlling High Blood Pressure <140/90 mm/Hg in members 18 - 85 years of age	0%	1	1	0	100%
Cervical Cancer Screening of women ages 21 - 64 years	0%	15	6	9	40%
Chlamydia Screening in Women aged 16 - 24 years	0%	1	0	1	0%
Colorectal Cancer Screening for members ages 46 - 75 years	0%	5	2	3	40%
Appropriate Testing for Pharyngitis for members aged 3 years and older	0%	6	6	0	100%
Eye Exam with Diabetes for members aged 18-75 years	0%	4	0	4	0%
Hemoglobin A1c (HbA1c) control (<8.0%) for members aged 18-75 years	0%	4	0	4	0%
Initiation of SUD Treatment for members aged 13 years and older	0%	1	1	0	100%
Engagement of SUD Treatment for members aged 13 years and older	0%	1	1	0	100%
Kidney Health Evaluation for Patients With Diabetes 18 - 85 years of age	0%	3	0	3	0%
Use of Imaging Studies for Low Back Pain for members aged 18-75 years	0%	1	1	0	100%
Plan All-Cause Readmissions for discharges between January 1 and December 1	0%	1	0	1	0%
Appropriate treatment with upper respiratory infection for members aged 3 month and older	0%	18	14	4	78%

Medical Records Compliance Audit

Starts during the summer after HEDIS

Audits performed on 30 randomly selected primary care providers regardless of the number of members

Reviews completed on up to five random records and up to five providers

MEDICAL OFFICE RECORD COMPLIANCE AUDIT

PROVIDER ID:
CLINIC:
ADDRESS:

N / A = Not applicable
1 = present
0 = Not present

	I. GENERAL DOCUMENTATION	Provider 1	Provider 2	Provider 3	Pro
1	Complete member demographic information - including sex, employment and responsible party				
2	All pages in chart contain name or ID #				
3	Provider identified on each entry				
4	Chart entries are dated and signed				
5	All chart entries are legible				
6	Signed and Dated Consent Forms - HIPAA and Consent to Treat				
7	Documentation of after-hours call or treatment				
8	Review of consults, labs and other studies				
9	ER and/or Hospital records present				
10	**Coordination of care between PCP/Specialist/BH - Not scored, but assessed**				
	II. MEDICAL / SOCIAL HISTORY / MEDICAL MANAGEMENT				
11	Allergies/adverse reactions or NKA documented				
12	Updated problem list				
13	Updated medication list utilized				
14	Family medical history				
15	Past medical history/dental history, if available				
16	Social history (age 18 or older)				
17	History of smoking habits noted (starting age 11 yrs)				
18	History of alcohol usage noted (starting age 11 yrs)				
19	History of substance abuse noted (starting age 11 yrs)				

Quality Takeaways

Reporting services back to use:

- Helps us to report HEDIS rates accurately.
- Provides you with your bonus and incentive programs.
- Allows members to get the best quality of care possible.

Community Outreach

Focus of Community Outreach

Redeterminations

Renewal occurs every 12 months from the date of enrollment

Encourage your patients to make sure their addresses are up to date with Healthy Connections

Maximus offers provider training on enrollment process and how to support members choosing a health plan. Email providertrainings@maximus.com

Visit www.scchoices.com for more information.

Member Annual Eligibility

Ways for members to apply or renew:

- Online: apply.scdhhs.gov
  - Select Apply for Medicaid or Submit Annual Review
- Fax: 888-820-1204
- Phone: 800-726-8774
- Email: 8888201204@faxscdhhs.gov
- Mail: SCDHHS Central Mail

  P.O. Box 100101

  Columbia, SC 29202
- In person: Visit a local eligibility office.

Healthy Rewards for Members

Completing the Personal Health Assessment (PHA): **$20**	Creating a My Health Toolkit account: **$20**	Prenatal care visit: **$25**	Postpartum care visit: **$50**	Well-child visits 1 – 6: **$10x6**
Later well-child visits 7 – 8: **$10x2**	Annual checkup (3 – 21 years): **$25**	Pap test: **$25**	Breast cancer screen: **$25**	Chlamydia screen: **$25**
HPV vaccine (9-13 years): **$20**	Diabetes eye exam: **$25**	Diabetes blood test: **$25**	Flu shot: **$20**	

Eligibility/limitations may apply. Visit www.HealthyBlueSC.com for details.

2024 Additional Services Program Overview

Children

- Blue Book Club
- Tutoring Support
- Headset for Learning
- Scouts BSA
- Girl Scouts Leadership Experience
- Boys & Girls Club Fees
- Sports Physical
- Internet Essentials

Adults

- Adult Vision Care
- GED Ready Assessment Exam
- Uber/Lyft Transportation
  - Career Opportunities

Prenatal and Postpartum

- Diapers for Babies
- Car Seat Benefit
- Electric Breast Pump
- Sam's Club Membership
- Prenatal Pharmacy & Nutrition Education Support
- Home Delivered Meals

Care Management

- Asthma Products
- Fresh Fruits & Veggies
- Annual Oil Change
- Uber/Lyft Transportation - Care Management

All Members

- Weight Management Program *(10yrs & older)*
- Tobacco Cessation Program *(12yrs & older)*
- Cellular Benefit Program
- No Referrals
- Community Resource Link
- OTC Drugs with RX
- Med Sync Program
- Blue365

Eligibility/limitations may apply. Visit www.HealthyBlueSC.com for details.

How Community Outreach Supports You

Community Outreach can support your office by:

- Offering health education resources.
- Providing giveaway items.
- Distributing posters with QR codes that patients can use to update their address.
- Sponsoring clinic days to close gaps in care.
- Supporting and sponsoring events like:
  - Baby showers and diaper days.
  - Back to school events.
  - Patient appreciation days.
  - Health fairs.

Community Outreach Contacts

Midlands Region

Marcell Barnes, Jr.

Marcell.BarnesJr@HealthyBlueSC.com

Pee Dee Region

Nathan Cox

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Lowcountry Region

Jessica Barnett

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Upstate Region

Leslie Bruton

Leslie.Bruton@HealthyBlueSC.com

Community Outreach Territory Map

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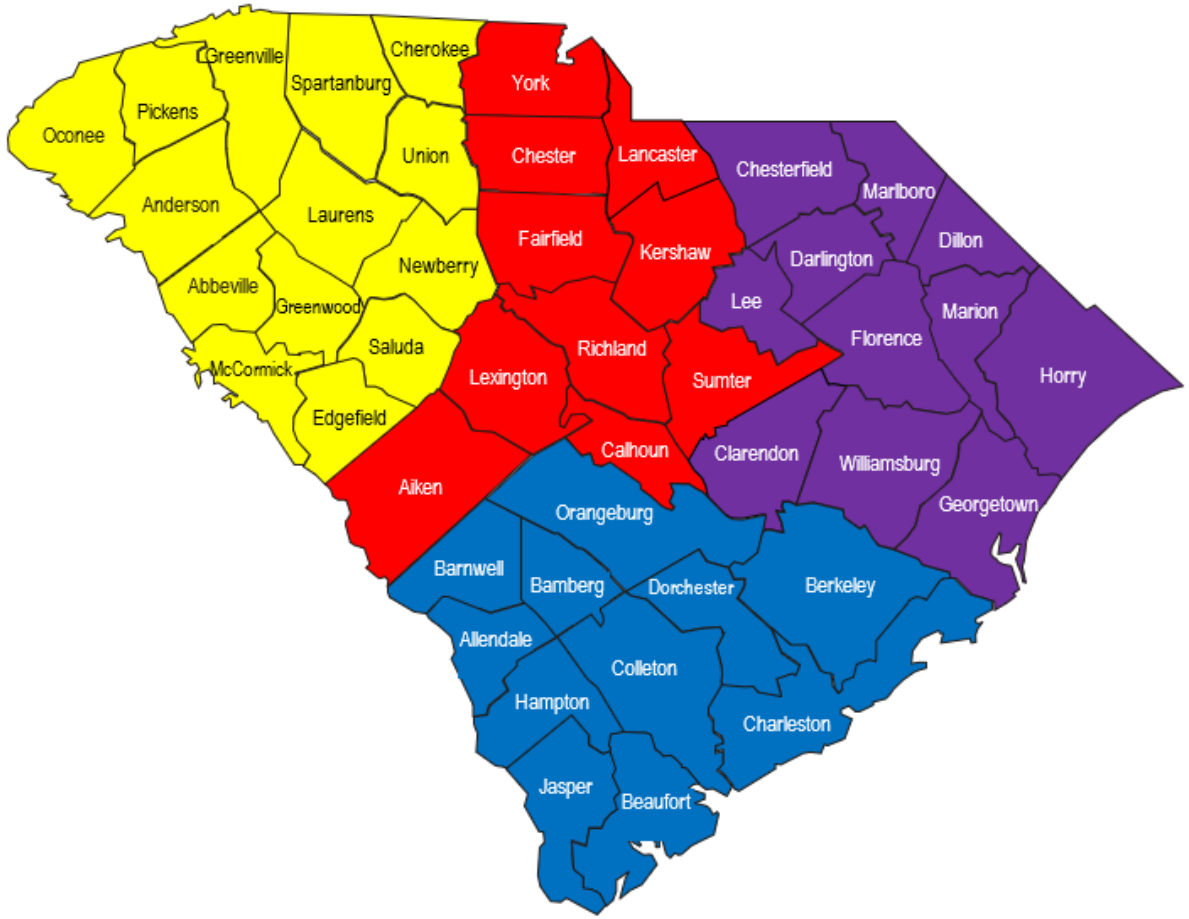

Community Outreach Pictures

Community Action Transit (C.A.T)

Attends events

Includes interactive gaming system

Follow Us on Social Media

@HealthyBlueSC

@HealthyBlueSC

@HealthyBlueSC

#HealthyBlueSC

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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BlueChoice® HealthPlan of SC

Healthy Connections