



South Carolina

Claims

BlueCross BlueShield of South Carolina

Disclaimer

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



Submission of Claims

Ways to Submit Claims

- Claims can be submitted:
 - Electronically through your clearing house (preferred method)
 - Use the appropriate payor ID number
 - Using My Insurance ManagerSM
 - Select Original Claim on the Claim Information page
 - By mail
 - Use the appropriate address on the back of the member's ID card

Submitting Claims Electronically

- Submitting claims electronically through your clearinghouse is the preferred method.
- Benefits of electronic submissions include:
 - Quicker turnaround time
 - Shorter reimbursement cycles
 - Improved cash flow
 - Reduced administrative burden
 - Payer compliance and data security
 - Ability to catch errors that may delay processing

Medical Plan Payor IDs	
State Health Plan	00400
BlueCross BlueShield of South Carolina	00401
Federal Employee Plan (FEP)	00402
Healthy Blue SM	00403
Planned Administrators, Inc. (PAI)	00886
BlueChoice [®] HealthPlan	00922
Medicare Advantage	00C63
Dental Plan Payor ID	
BlueCross BlueShield of South Carolina	38520

BlueChoice HealthPlan is an independent licensee of the Blue Cross Blue Shield Association.

Submitting Claims through My Insurance Manager

- Submitting claims through My Insurance Manager is quick and easy.
- When you hover over Patient Care, you will see the option to enter institutional or professional claims for health services, as well as claim entry for dental services.
- This option should be used for claims that you cannot get through your clearinghouse.

Patient Care	Office Management	Resources	Modify Profile
Health			
▶ Authorization Extension		▶ Patient Directory	
▶ Authorization Status		▶ Pre-Certification/Referral	
▶ Claims Status		▶ Superbill Maintenance	
▶ Eligibility and Benefits		▶ Pre-Service Review for Out-of-Area Members	
▶ Institutional Claim Entry		▶ Professional Claim Entry	
▶ Other Health Insurance		▶ Verify Primary Care Physician	
Dental			
▶ Claims Status		▶ Patient Directory	
▶ Dental Claim Entry		▶ Superbill Maintenance	
▶ Eligibility and Benefits		▶ Pre-Treatment Estimate Entry	
▶ Other Dental Insurance		▶ Pre-Treatment Estimate Status	

Submitting Claims by Mail

While electronic submission is the preferred method for submitting claims, we do allow providers to submit their claims by mail. The addresses include:

BlueCross BlueShield of South Carolina

(Columbia Service Center)

PO Box 100300
Columbia, SC 29202

BlueCross BlueShield of South Carolina

(Greenville Service Center)

PO Box 6000
Greenville, SC 29606

State Health Plan

PO Box 100605
Columbia, SC 29260

Federal Employee Program

PO Box 600601
Columbia, SC 29260

BlueChoice HealthPlan

PO Box 6170
Columbia, SC 29260

Medicare Advantage

PO Box 100191
Columbia, SC 29260

Important Information on Corrected Claims

- Corrected claims can be submitted:
 - Electronically (through your clearinghouse)
 - Use the appropriate payor ID.
 - For institutional claims, use frequency code 7 (which indicates an adjustment).
 - For professional claims, enter the original claim number in Box 22 of the CMS-1500.
 - *Include a description for the reason of the adjustment in Box 19.*
 - Using My Insurance Manager
 - Select Replacement of Prior Claim on the Claim Information page.
 - By mail
 - Use the appropriate address on the back of the member's ID card.
 - Be sure to label the claim as a corrected claim.
- For all avenues, include all lines from the original claim, along with the correction(s) needed.



Claim Reminders

Laboratory Services

- Avalon Healthcare Solutions manages the laboratory benefits on behalf of BlueCross and BlueChoice®.
- Access the current list of participating laboratories on the BlueCross or BlueChoice website.
- Review the medical policies before rendering services to ensure criteria is followed for coverage.
- Benefits of reviewing the medical policies:
 - Prevents delays in claims processing
 - Ensures proper and timely payment
 - Reduces the need for reconsiderations

Avalon is an independent company that assists with utilization management on behalf of BlueCross BlueShield of South Carolina and BlueChoice HealthPlan.

Medical Policy Criteria for Laboratory Services

Definition
Procedure is not covered under the member's benefit due to exclusion
Limitations based on the member's age/sex
Total units within and across claims for a single date of service more than necessary
Maximum allowable units within a defined period of time has been exceeded
Minimum time required before a second procedure is warranted
Providers/procedures not permitted in combination
Procedure was not appropriate for the clinical situation
The procedure is not valid with other procedures on the same date of service

Examples of claims that rejected due to policy criteria not being met:

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

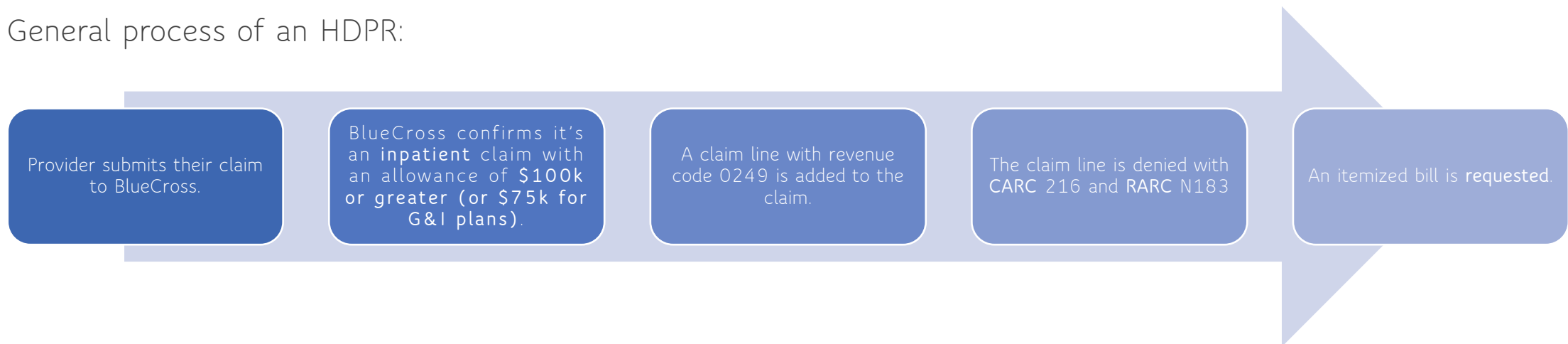
Locating Medical Policies

- Medical policies can be found on:
 - www.SouthCarolinaBlues.com
 - Providers>Policies and Authorizations>Medical Policies
 - www.BlueChoiceSC.com
 - Providers>Medical Policies
 - www.SCBluesMedAdvantage.com
 - Providers>Live Medical Policies
- CPT and diagnosis codes listed on each policy are not a guarantee of payment.
 - Included for general reference.
 - Lists may not be all-inclusive.

The screenshot shows a website titled "Medical Policies" with a dark blue header. The header contains navigation links: HOME, CONTACT US, ACCESSIBILITY, and DISCLAIMER. Below the header is a search bar with the text "Search..." and a magnifying glass icon. A horizontal menu of letters (A-Z) is visible below the search bar. The main content area is divided into two columns. The left column has two sections: "Category" and "Date Posted". The "Category" section lists various medical categories with their respective counts in parentheses, such as "Medicine (123)", "Administrative (25)", "Other (32)", "Durable Medical Equipment (39)", "Prescription Drug (83)", "Laboratory (138)", "Surgery (126)", "Therapy (80)", "Radiology (95)", "Mental Health (6)", "Ob/Gyn/Reproduction (10)", and "All (757)". The "Date Posted" section lists dates and their counts, such as "October 2022 (1)", "September 2022 (1)", "August 2022 (3)", "July 2022 (2)", "2021 (33)", "2020 (58)", "2019 (31)", "2018 (23)", and "All (757)". The right column displays a list of medical policies, each with a title and a date. The policies listed are: "Abatacept (Orencia®)" (Prescription Drug | April 1, 2014), "ABDOMEN MRA (Angiography)" (Radiology | January 1, 2021), "Abdominoplasty, Panniculectomy and Lipectomy" (Surgery | June 1, 2015), "Ablation of Peripheral Nerves to Treat Pain" (Surgery | May 1, 2016), "Absorbable Nasal Implant for Treatment of Nasal Valve Collapse" (Surgery | October 1, 2019), "Accelerated Breast Irradiation and Brachytherapy Boost After Breast-Conserving Surgery for Early-Stage Breast Cancer" (Therapy | July 1, 1996), and "Accident and Medical Emergency Services" (Administrative | January 15, 1997).

High Dollar Pre-payment Review (HDPR)

- The process of reviewing high dollar inpatient institutional claims.
- Used to validate the services billed align with what was rendered.
- The following criteria must be met for an HDPR:
 - It is an inpatient institutional claim.
 - The allowed amount of the claim is \$100,000 or greater (or \$75,000 for Group and Individual plans).
 - Any pricing methodology that involves a discount except for:
 - Per-diem
 - Flat-fee case rate
 - DRG rate
- General process of an HDPR:



Examples of Itemized Bills

- Acceptable itemized bill:

42 Rev. Co.	43 Description	44 HCPCS/Rate/HPPS Code	45 Serv. Date	46 Serv. Units	47 Total Charges
0250	Midazolam 10 MG	J2250	010326	2	29.09
0272	Guidewire 3CM	C1769	010326	1	3597.00
0278	Device closure	C1760	010326	1	2563.00

- Unacceptable itemized bill:

42 Rev. Co.	43 Description	44 HCPCS/Rate/HPPS Code	45 Serv. Date	46 Serv. Units	47 Total Charges
	Pharmacy		010326	336	7780.81
	Sterile supplies		010326	8	7680.40
	Supply/implant		010326	2	6385.00

Claim Attachments in My Insurance Manager

- Claim Attachments is a feature in My Insurance Manager that allows you to upload requested documentation directly into the portal for a claim.
 - 30 MB limit for each document.
- Documentation that can be uploaded includes:
 - Accident questionnaires
 - Certificate of medical necessity (for DME)
 - Medical records
 - Other health insurance
 - Primary explanation of benefits
 - Itemized bills

Attachments

i This claim may require additional documentation.
The documentation requested is: **[Document Type]**.
To attach the documentation, click the attachment link below.
Please note: We currently only accept PDF files at this time.


[Attach \[Document Type\] Documentation](#)

Here is a list of the line items associated with this claim.

Line Summary List **Showing 1 Results**

Provider Reconsiderations – Local Requests

- A provider reconsideration is a one-time courtesy review offered to participating providers used to investigate the outcome of a processed claim.
 - Typically related to medical necessity, lack of authorization for emergent services, etc.
- Use the South Carolina Provider Reconsideration Form.
 - www.SouthCarolinaBlues.com
 - www.BlueChoiceSC.com
- Include supporting documentation.
 - History and physical records
 - Operative notes
 - Office notes
 - Progressive notes
- Be mindful of the timely filing limits.



Independent licensees of the Blue Cross Blue Shield Association.

South Carolina Provider Reconsideration Form

This form is intended for use by participating physicians and other health care professionals in South Carolina. If you are located outside of South Carolina and have claims questions, reviews, or appeals, please direct them to your local Blue plan.

To request a one-time claim review for reconsideration, please complete this form for BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan members. Use this form as the cover transmittal sheet for all supporting documentation. Forms submitted without supporting documentation will not be considered. Be sure to complete each section.

Refer to the Provider Reconsideration Guide online to determine if a provider reconsideration is warranted for the claim in question.

Provider Information

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

Phone Number: _____ Ext: _____ Fax Number: _____

Contact Person: _____ Email: _____

Authorized Signature: _____ Date: _____

Patient and Claim Information

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

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

Reconsideration

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

Medical Services Laboratory Services

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


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

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

Plan	Reconsideration Time Limits	Fax Number	Mailing Address
BlueChoice®	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
BlueEssentials™ & Blue Option™	180 days from remit date	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
Preferred Blue® & BlueCard®	Varies by plan	803-264-4172	AX-620, I-20 @ Alpine Road, Columbia, SC 29219
Group & Individual	180 days from remit date	803-264-4172	AX-F25, I-20 @ Alpine Road, Columbia, SC 29219
State Health Plan	6 months from remit date	803-264-4204	AX-B10, P.O. Box 100605, Columbia, SC 29260

Provider Reconsiderations - BlueCard® Requests

- For South Carolina providers requesting a review of the BlueCard claim (member belongs to another Blue® plan).
- Use the BlueCard Claim Appeal Form.
 - www.SouthCarolinaBlues.com
- Include supporting documentation.
 - History and physical records
 - Operative notes
 - Office notes
 - Progressive notes
- Timely filing limits will depend on the member's Home plan.



Appendix D: Provider BlueCard Claim Appeal Form
*Denotes required field

*Today's Date (MM/DD/YY):	
PROVIDER INFORMATION	
*Provider Name	*Contact Name
*NPI	*Contact Phone Number
Contact Email	Contact Fax Number
*Contact Address	
MEMBER/CLAIM INFORMATION	
*Member Name	*Claim Number
*Member ID (including prefix)	*Denial Code(s)
*Date(s) of Service (MM/DD/YY)	
TYPE OF APPEAL*	
(CHECK ONE OF THE FOLLOWING REASONS FOR DENIAL OR CLAIMED UNDERPAYMENT, AND ATTACH ALL SUPPORTING DOCUMENTATION, INCLUDING ANY NECESSARY MEMBER AUTHORIZATION)	
<input type="checkbox"/>	Contract Term(s): Original claim was not paid or processed in accordance with contract terms.
<input type="checkbox"/>	Coordination of Benefits: Original claim denied or closed pending receipt of additional information from another insurer or other reason related to COB.
<input type="checkbox"/>	Corrected Claim: Previously processed claim was denied for a defect and/or error and requires a correction. Please specify the correction to be made: _____
<input type="checkbox"/>	Duplicate Claim: Original claim denied as duplicate to a previously finalized claim.
<input type="checkbox"/>	Timely Filing: Original claim denied for untimely filing (and proof of timely filing is attached).
<input type="checkbox"/>	Precertification/notification or Prior-Authorization: Original claim denied or Provider received reduced payment for failure to notify or pre-authorize services or exceeding authorized limits (and proof of valid notification/authorization is attached).
<input type="checkbox"/>	Medical Necessity: Original claim denied as a result of medical necessity/utilization review decision.
<input type="checkbox"/>	Referral Denial: Original claim denied as invalid or missing a required referral.
<input type="checkbox"/>	Request for Additional Information: Original claim denied due to missing or incomplete information

Reconsideration, Corrected Claim or Provider Services

- Knowing when to submit a provider reconsideration versus a corrected claim or contacting Provider Services is important.

Examples of when to submit a provider reconsideration:

Provider reconsideration

A claim is rejected because the medical necessity could not be determined.

A claim is rejected for lack of authorization, but the member was comatose when they arrived at the hospital.

Examples of when to submit a corrected claim:

Corrected claim

An anesthesia claim is submitted with the incorrect modifier and rejects as a duplicate.

A provider only performs the Cesarean delivery but submits their claim with the procedure 59515 (which includes postpartum care), causing the claim to process globally.

Examples of when to contact Provider Services:

Provider Services

A corrected claim was submitted but rejected as a duplicate.

A claim is rejected for no prior authorization, but you have the approved authorization number.

Pricing Inquiries

- A pricing inquiry is an investigation of the reimbursement applied to a claim.
- Before submitting pricing inquiries, verify the following:
 - Member's plan (i.e., commercial, Exchange or Medicare Advantage)
 - Non-covered charges or denied lines
 - Applied cutbacks
 - Date of service in comparison to fee schedule year
 - Medically unlikely edits (MUEs)
- If using a third-party vendor to submit inquiries on your behalf, be sure they are aware of this information.

Ancillary Claim Filing Guidelines

- Durable medical equipment
 - File to the plan whose state the equipment was purchased at a retail store; or
 - File to the plan whose state the equipment was shipped
- Independent clinical laboratory
 - File to the plan where the specimen was drawn
 - The location of where the specimen was drawn is determined by the physical location of the referring provider
- Specialty pharmacy
 - File to the plan whose state the ordering physician is located

Submission of Medical Records

- If medical records are requested, be sure to submit them as soon as possible.
- Medical records could be requested to:
 - Adjudicate claims.
 - Support medical necessity for a denied claim.
 - Close gaps in care for quality measures (HEDIS[®]) based on claim history.
- The **submission of medical records is a non-billable event**.
 - Share this information with any third-party vendors that submit medical records on your behalf (i.e., Ciox, ScanSTAT).

HEDIS: Healthcare Effectiveness Data and Information Set

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

National Drug Codes

- National drug codes (NDCs) are used when submitting claims for drugs.
- NDCs must have 11 digits and follow the 5-4-2 format.
- If the drug package lists an NDC with 10 digits, it must be converted into an 11-digit NDC using the following table:

10-Digit Format		Add a zero in...		Report NDC as...
4-4-2	#### - #### - ##	1 st position	0#### - #### - ##	0#####
5-3-2	##### - ### - ##	6 th position	##### - 0### - ##	#####0#####
5-4-1	##### - ##### - #	10 th position	##### - ##### - 0#	#####0#

BlueCard Program

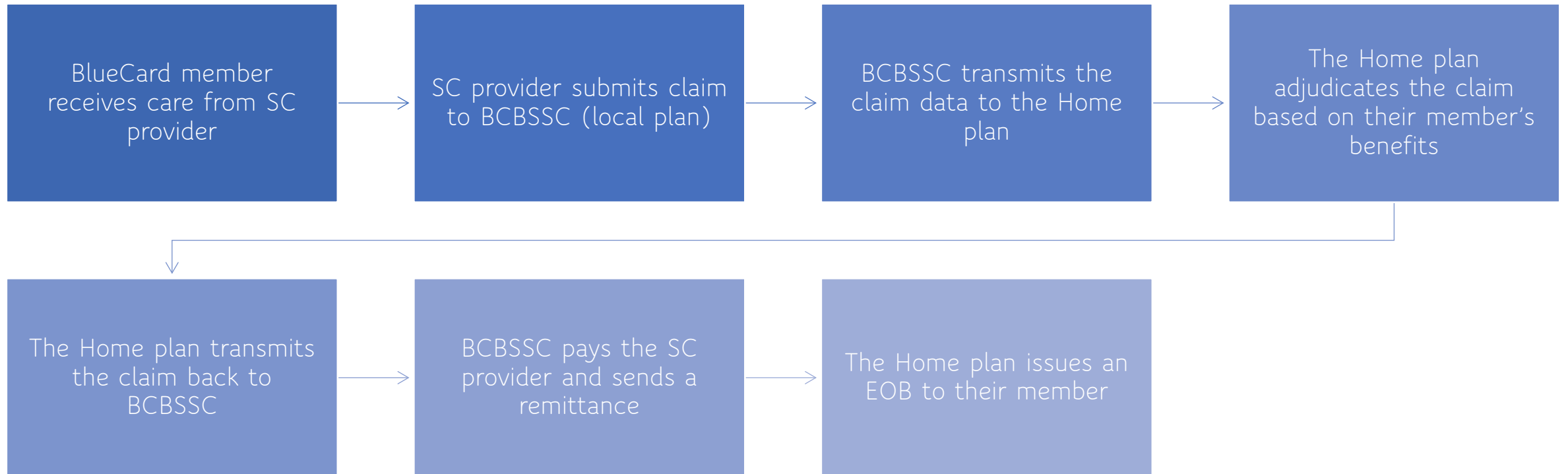
Overview

- The BlueCard program allows Blue plan members to get health care services while traveling or living in another Blue plan's service area.
- The program links participating health care providers across the country and internationally through a single, electronic network for claims processing and reimbursement.

Benefits to Providers

- Let's you conveniently submit claims for members from other Blue plans directly to BlueCross BlueShield of South Carolina.
- Gives you one point of contact for all your claims-related questions.

BlueCard Process Flow





Helpful Tips

Claims Requiring Questionnaire Responses

- Accident or subrogation
 - Generated based on trauma related diagnoses on a claim
 - Allow members at least 60 days to respond and for the review to be completed
- Other health insurance (OHI)
 - Generated based on the member's age, if they have more than one policy on file, etc.
 - Must be completed by the member.
 - Members can mail or fax the questionnaire, call Member Services or update their information using My Health Toolkit.
- For both, encourage members to return the questionnaire as soon as possible to avoid processing delays
- Incorporate the forms in the onboarding paperwork, but only submit the documentation if requested
 - Both forms are available on applicable websites.
 - Be sure the form being used is applicable to the member's plan.

Importance of Correct Coding

- Accurate coding and reporting of services on medical claims is critical in assuring proper payment to providers.
- Common coding issues include:
 - Invalid modifiers
 - Incorrect number of units
 - Diagnosis inconsistencies
 - Unbundled services
 - Age discrepancies
 - Unspecified codes
- This list may not be all-inclusive.



Available Resources

Ask Provider Services Feature

- Ask Provider Services is a feature in My Insurance Manager that lets you submit secured web inquiries for help with claims.
- This feature is intended to assist with complex issues and not general claim questions where the answers can be found in the portal or the VRU.

Examples of appropriate requests	Examples of inappropriate requests
Why was line one of the claim denied as noncovered?	What is the status of the claim?
Has the member returned the coordination of benefits questionnaire?	Has the claim been processed?
I need clarification regarding a recent recoupment made on the claim for date of service 01/30/2025.	Did you receive the medical records for this claim?
Claim denied for no authorization, but the authorization number is on file under 123456789.	Is there a claim on file for date of service 07/10/2025?

STATchatSM

- STATchat is a feature that let's you speak with a Provider Services representative.
- The feature is available through My Insurance Manager.
- System requirements include:
 - A current version of Adobe Flash Player
 - A compatible web browser, such as Microsoft Edge or Google Chrome.
 - A headset or standalone microphone with speakers connected to your computer.
- The operation hours may vary by line of business.

The image displays two overlapping screenshots of the STATchat interface. The background screenshot shows a form titled "STATchat" with a red asterisk indicating a required field. The form includes a message: "Use the form and receive a response in the Message Center. Please be aware during our peak season that there may be a delay in receiving a response. You may also talk to a Provider Services representative with STATchat." Below this, there are radio buttons for "Submit your question online" and "Talk to Provider Services online" (selected), with a note "(Monday - Friday, 8:30 a.m. to 8 p.m. EST)". The form also has fields for "Inquiry Name" (BlueCross BlueShield Plans), "Inquiry Reason" (Claim Status Inquiry), "Patient's First Name" (J), "Patient's Last Name" (K), "Patient's Member ID" (8199Q), "Location" (with a "Select" button), and "Primary ID" (1). A "Launch STATchat" button and a "Back" link are at the bottom.

The foreground screenshot shows a Google Chrome browser window titled "STATchat - Google Chrome" with the URL "myhealthtoolkit.com/wps/myportal/hcp/providers/utilities/ask...". The interface is split into two main sections: "STATchat" and "Hang Up". The "STATchat" section shows a status bar with a progress indicator, "Status: Connected", and "Call Id: 8789141651". The "Hang Up" section has a "Wearing a headset?" checkbox (checked) and a numeric keypad with letters assigned to numbers: 1, 2 (ABC), 3 (DEF), 4 (GHI), 5 (JKL), 6 (MNO), 7 (PQRS), 8 (GHI), 9 (WXYZ), *, 0 (*), and #. Below the keypad are "MUTE" and "KEYPAD" buttons. At the bottom, there are "Details" and "Log" tabs, and a "Details" panel showing "Automatic Number Identification" (8789141651), "Session ID", and "Provider Tax ID" (571098556).



THANK YOU!