Third Quarter 2021

BlueNews℠ for Providers

BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

90-Day Provider Validation Requirements

Provider demographic data can change frequently throughout the year and in our networks. To ensure our members know where to find the right physicians or facilities for the care they need, it is vital that we validate the accuracy of their contact information regularly. As part of the No Surprises Act, set to go into effect on **Jan. 1, 2022**, providers are required to verify and/or update their demographic data at least **every 90 days**. This includes both individual physicians and facilities.

Validations should be completed using M.D. Checkup, which is in My Insurance Manager℠ (MIM) and the 90-day time frame will be based on the number of days since the last validation was made. If more than 90 days has passed since the provider's last validation, we are required to remove them from our directories.

M.D. Checkup can also be used if updates are needed. Once the changes have been made, we will have our directories updated with the new data within two business days of receipt.

My Insurance Manager Updates

Authorization Enhancements

On Aug. 13, 2021, enhancements were made to the Fast-Track option in My Insurance Manager (MIM). To help eliminate the need for multiple clicks, you can now search for different Fast-Track authorization requests using keywords, CPT/HCPCS codes or diagnosis codes. An added plus is that the returned results include not only the keyword(s) or codes entered but also different types and places of service. All these enhancements ensure you locate the proper authorization for the service(s) being rendered.

You still receive the appropriate message indicating that prior authorization is not needed for services that do not require approval. Also, if the service has been outsourced (e.g., high-tech imaging), you still receive a message explaining how to complete the authorization process with the outsourced vendor (e.g., NIA™ Magellan).

Refund Letters

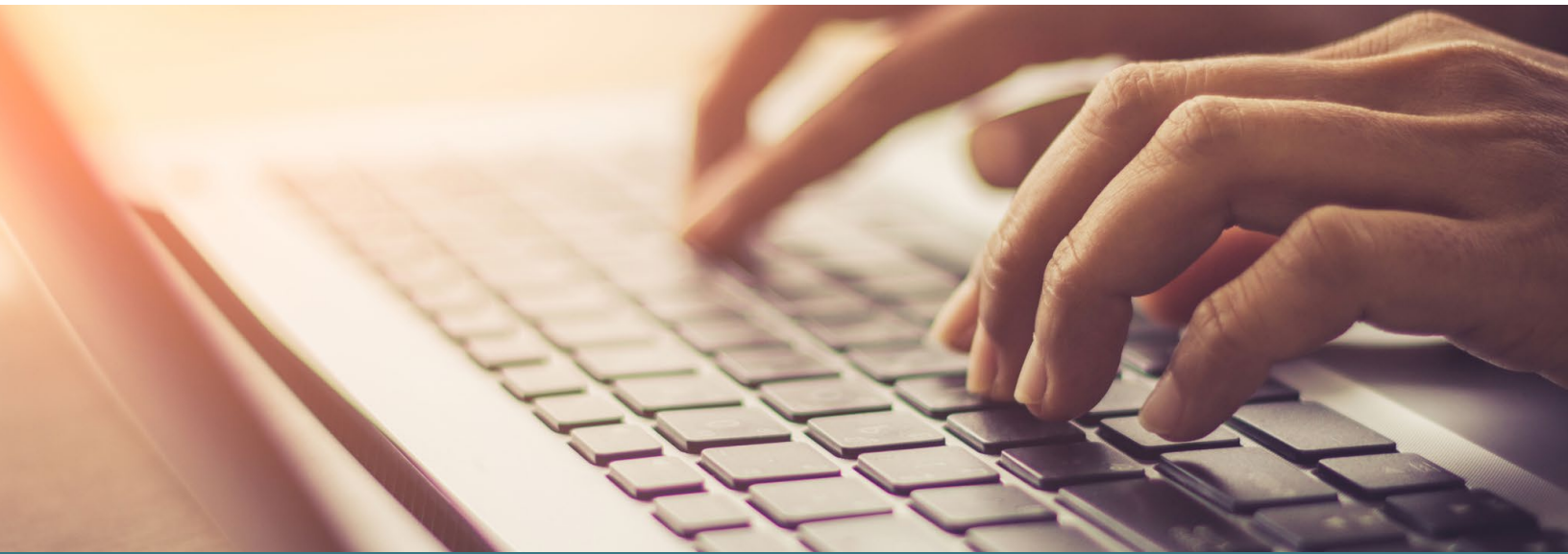
Great news! Provider refund letters are now available in My Insurance Manager (MIM). The letters provide you with the reason for the refund request along with the patient and claim details. If an offset takes place, an offset letter will be available for you to view.

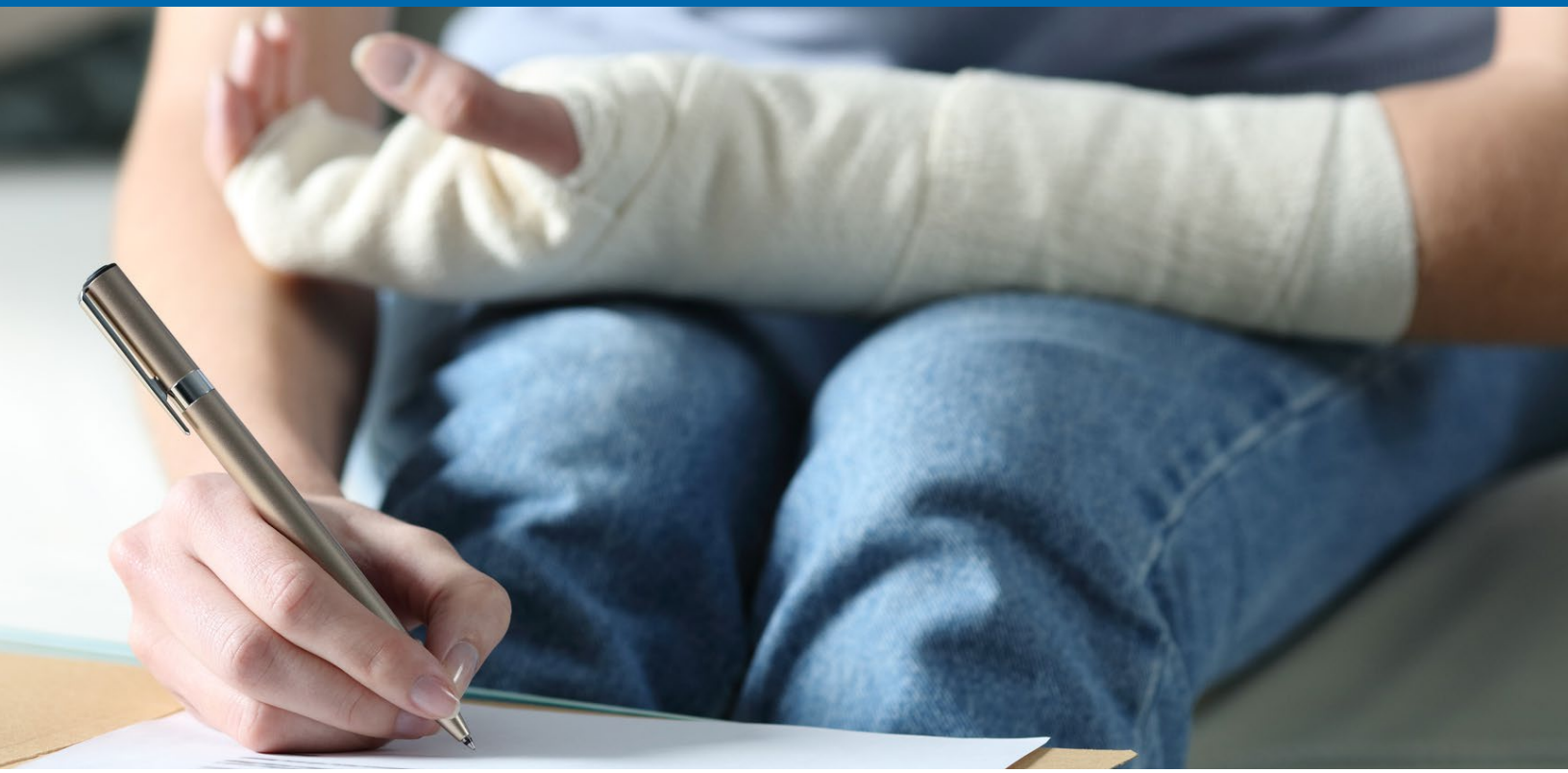
By viewing these letters in MIM, you save time and effort. The information is at your fingertips, allowing you to settle any open patient accounts, balance your books and more. All the pertinent details related to the refund are available without having to call Provider Services; however, the phone number to Provider Services is included in case further assistance or information is needed.

To pull the refunds letters, follow these quick steps:

1. **Log in to MIM.**
2. **Hover over Office Management and select Refund Letters.**
3. **Enter the refund control number (RCN) from your remittance or search by the posting date.**
4. **Select the letter you wish to view.**

*Note: The RCN is located on your remittance under **Provider Adjustment**. Also, when searching by the posting date, you can choose from the current month, a date range or a specific date. A specific location can be chosen as well when more than one is listed in our database.*





Accident Questionnaires

Has your patient received a request for an accident questionnaire? Accident questionnaires are automatically generated to the member if there are trauma-related diagnosis codes on the claim.

The questionnaire is often overlooked by the member or is returned incomplete and without sufficient information to determine if the service was related to an event for which a third party may be responsible.

Under both scenarios, multiple attempts are made to reach the member. It is ultimately his or her responsibility to return the completed questionnaire with all required information. For this reason, we ask that you allow the member at least 60 days to respond and for us to complete our review of the submitted information.

How can you help?

If your claim has been denied pending an accident questionnaire response, as a health care provider, you can:

- Contact your patient to encourage them to complete and return the questionnaire. Members can respond to the questionnaire via mail, calling the customer services number on the back of their ID card, or online using the website located on their ID card.

- Have members complete the accident questionnaire at the time of service. However, only submit the questionnaire on behalf of the member if your claim is pending for this reason.

Not all claims require the questionnaire, and we want to avoid receiving unwarranted questionnaires. Also, be sure the accident questionnaire is completed and signed by the member.

If 60 days have passed from the processed date of the claim, you may do one of these two things:

- Submit the questionnaire completed by the member at the time of service.

- Submit medical records in lieu of the questionnaire.

If submitting medical records, please note the following:

- Medical records should be submitted using the appropriate avenues for document submission (e.g., My Insurance Manager, fax, etc.) and should provide all information related to the service.

- Submission of medical records does not guarantee claims will be released for processing. Medical records may be inconclusive for information we might need (such as auto insurance details). Therefore, the best practice is to have the patient complete the accident questionnaire at the time of service when feasible.

- Please include any phone numbers or email addresses you may have for your patient. This will assist us in reaching out to the member if any additional information is still needed.

- Medical records will not be accepted after the timely response date. We encourage you to submit medical records within six months of the process date of the claim.

Welcome to the Team!

This quarter, we would like to welcome three wonderful ladies to Provider Relations and Education. Each of them brings a vast amount of knowledge and skills that will make them a great asset to the team. The new representatives are being trained and should be fully acclimated to their duties during the next quarter.

NAME: Donna Thompson

TITLE/RESPONSIBILITIES: Provider Relations Consultant

Hometown: Denmark, South Carolina

Years with BlueCross: 20

Brief Bio: Donna, a native of Denmark, South Carolina, has resided in the beautiful garden city of Orangeburg for 24 years. She is the wife of Patrick and proud mother of two boys, Zion and Canaan. Donna enjoys reading, attending local and Broadway plays, meeting new people, and serving her community. Donna's varied career includes training and education, customer service, network development and contracting, and public speaking. Donna is committed to service and strongly believes everyone should use his or her gift, whatever that may be, to serve others.

NAME: Annette Scott

TITLE/RESPONSIBILITIES: Provider Relations Consultant

Hometown: Hopkins, South Carolina

Years with BlueCross: 31

Brief Bio: Annette has been with the company for 31 years. During her tenure, she has held several positions to include customer service, project administration and management. Annette is happily married and is the mother of three and the grandmother of eleven. In her spare time, she enjoys cooking and spending time with her family and friends.

NAME: Jasmin Lee

TITLE/RESPONSIBILITIES: Provider Relations Consultant

Hometown: Detroit, Michigan

Years with BlueCross: 5

Brief Bio: Jasmin is a mom of one, bratty, spoiled pit bull named Chief and aunt of two nephews, a niece, and a host of friends' children that she considers to be her nieces and nephews as well. Jasmin is a foodie, but she only enjoys cooking for others. She loves to travel but COVID-19 has put a pause on that. Jasmin also loves all things artistic, learning and trying new things as long as it doesn't involve heights. Jasmin even has her own business, J. Wick & Co. She's truly excited to be on the team!

Quality Initiatives

HEDIS® season (Retrospective review) is just around the corner — January 2022 to be precise! In an effort to help reduce the strain on our PCP-type providers and even some of our specialty providers, we wanted to take a moment to talk about what is coming over the next few months and how we can work together to support quality patient care and reinforce patient safety.

Key Terms

National Committee for Quality Assurance (NCQA): They provide quality scoring metrics to the Federal Employee Program and CMS for the Affordable Care Act/Exchange and Medicare Advantage lines of business.

HEDIS: This refers to the Healthcare Effectiveness Data Information Set.

Quality Navigator (QN): This is a quality-trained team member with an RN license or bachelor's in a health care-related major who is trained on all things HEDIS and can help guide you and make your quality journey that much easier!

HEDIS Season/ Retrospective Review: This is a retrospective review or look-back of the prior measurement year's compliance.

Gap in Care (GIC): Based on NCQA metrics, our member/your patient is identified as being overdue for quality related care.

Prospective Season: This runs from Jan. 1 – Dec. 31 each year.

Measurement Year (MY): This runs concurrently with prospective season.

Eligible Provider: These are providers that are credentialed as a PCP type or credentialed as a specialist that relates specifically to the type of quality care-related documentation that is needed. For example, a cardiologist might get a request for a blood pressure reading on a hypertensive patient but would not receive a request for prenatal care.)

Prospective 2021MY (PCP Providers Only)

Time Frame

Now through Dec. 31, 2021

If you join us for the upcoming Annual Provider Summit, we will take a deeper dive, but the important thing to remember is that **we still have until Dec. 31, 2021, to get our members/your patients in for their overdue care.**

Gap in Care Reports

How to access your Gap in Care reports: Log in to **My Insurance Manager**. Select the Office Management tab. A drop-down menu will appear. Navigate to the right-hand column and select the HEDIS® Quality Reports link. If you have any issues, please reach out to **Navigator@bcbssc.com** with your tax identification number. We will connect you to your assigned Quality Navigator. He or she will be happy to walk you through how to register for the MIM portal and how to access your GIC reports, and he or she can do a deep dive into what these monthly reports contain.

If you have your monthly Gap in Care reports, **fear not!** You have until Dec. 31, 2021, to get any noncompliant members scheduled for their overdue care. Use the GIC reports to identify which members are due for care and which quality related measures they need.

Gaining Compliance

During prospective season, you can gain compliance through using quality codes via claims submission or setting up or enhancing an EHR data feed, medical records or compliance forms!

The fastest and easiest way to gain compliance is through submitting appropriate NCQA-approved quality codes via claims submission. If you need a copy of our Quick Reference Guide with examples of available NCQA-approved codes, please email us at **Navigator@bcbssc.com**. We would be happy to send this to you.

If you notice that you have members listed as overdue for care and you have already provided this care, reach out to **Navigator@bcbssc.com** with your tax identification number and let us know! This means that the excellent care you are giving is not being reported back to our plan, and we would love to connect you with your assigned Quality Navigator to discuss options for reporting this care back to us.

All compliant information that we receive during the prospective season will not be re-requested if the member is pulled into our **HEDIS Retrospective Review** sample! Basically, the more compliance information you share with us during the **measurement year**, the fewer medical record requests you will receive during **HEDIS season**.

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HEDIS Season 2022/Retrospective Review for 2021MY (All Eligible Providers)

Time Frame

January 2022 – April 2022

HEDIS. It's a word that sends chills down some providers spines, but it doesn't have to be that way! Every year, NCQA will select a sample of our membership that we are required to prove were given all the quality care they were due for in the prior measurement year. So, for this upcoming HEDIS season, we will be requesting records with 2021 (or earlier) dates of service. Any care given after Dec. 31, 2021, can help make that member compliant for 2022MY but will not impact them for HEDIS 2022, which is a retrospective review of care that was given or completed for the 2021MY.

The only way to make a member compliant once they have been pulled into our HEDIS Retrospective Sample is via medical record.

Pay attention to the medical record request cover sheets. These will indicate exactly what is needed for the individual member that was pulled into our sample. We only need the information requested on the cover sheet for the member. Each cover sheet will have what we are looking for and the time frame that the service must have been completed within. If you do not have the service documented or it was completed outside of the time frame requested, please make sure to indicate this on the cover sheet (there are check box options at the bottom of each sheet) and send this back to us. We are required by NCQA and our auditors to prove we received a response from every eligible provider.

These requests are based on claims we received from your practice during the time frame for each measure we are requesting. Please note that some measures have significant look-back periods (colorectal cancer screening has a 10-year look-back). As a contracted provider with BlueCross BlueShield of South Carolina, you are required to send back the requested documentation free of charge.

Since we are required to show a response from all eligible providers, the sooner you can respond to our requests, the sooner we can remove you from our email, mail and fax blasts.

Still Have Questions?

Want to talk to someone in person via WebEx or telephone?
Please email **Navigator@bcbssc.com** with your practice name and tax identification number. We can connect you to your assigned Quality Navigator.

Need To Get in Touch With Provider Relations and Education?

Provider advocates are always eager to assist you. If you have a training request, please contact your county's designated provider advocate by using the **Provider Advocate Training Request Form**. For questions about an ongoing education initiative or a recent news bulletin, submit the **Provider Education Contact Form**. These forms are located on the Provider Advocates page of our provider websites.

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