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

Independent licensees of the Blue Cross and Blue Shield Association

June 2017

My Insurance Manager℠
User Guide

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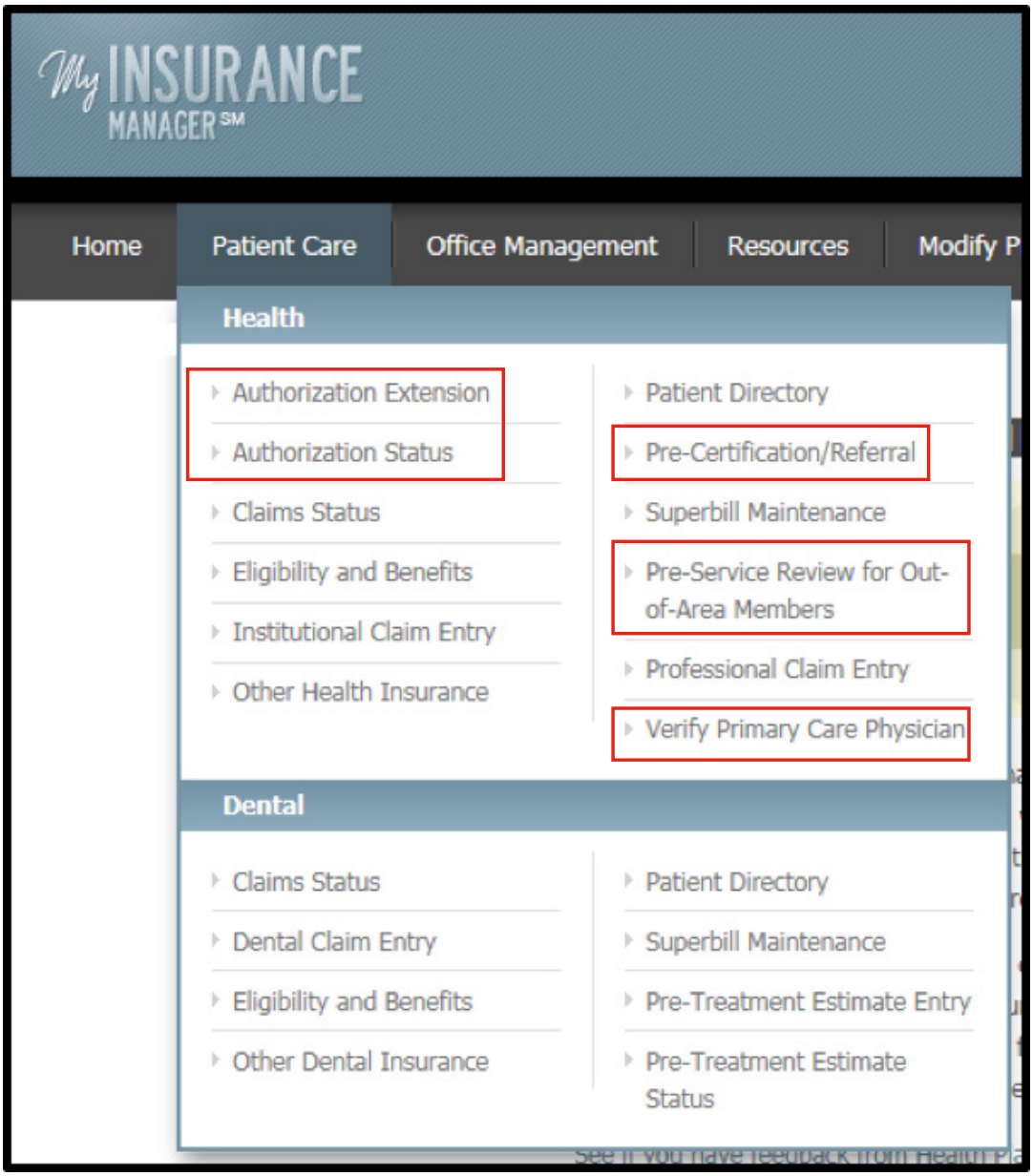
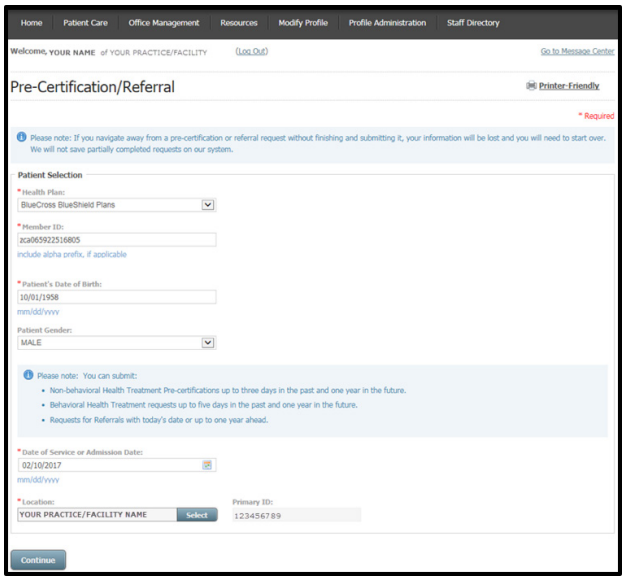
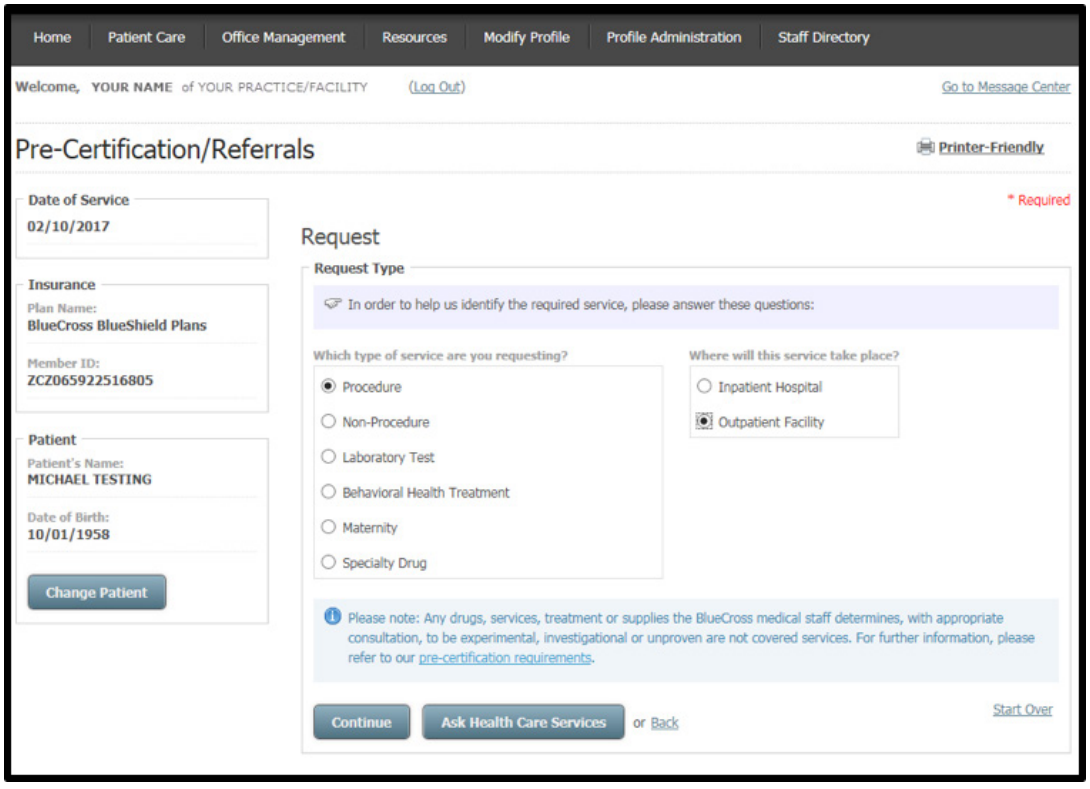


Pre-certification and/or referral requirements vary from group to group or by Plan.

Pre-Certification/Referral – General Instruction



From the Patient Care tab, select Pre-Certification/Referrals. Enter all required patient information. **Continue**.

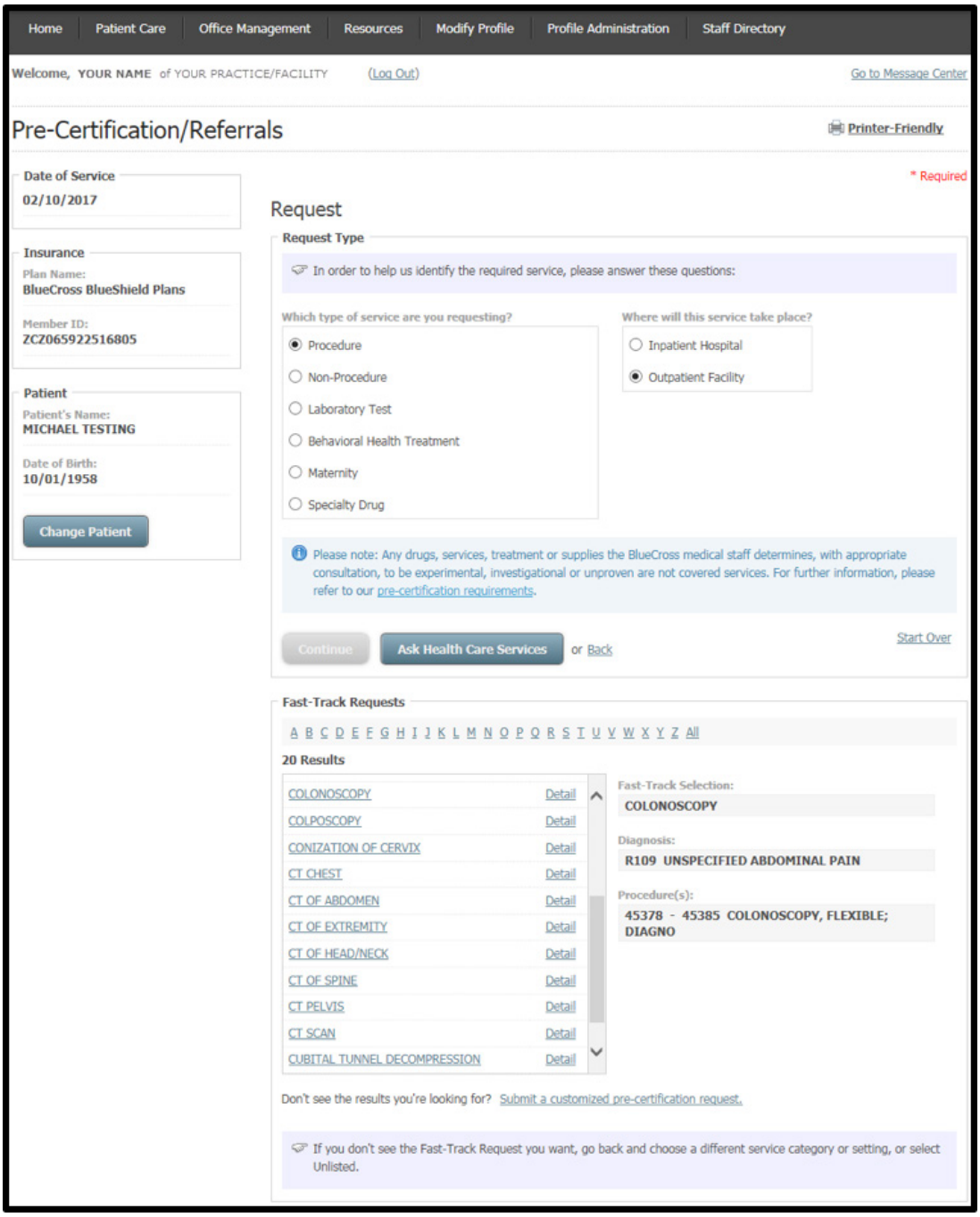


At the Request Type screen, choose the type of service and where the service will take place. Options for where the service will take place change with each type of service. Required fields for each request type option:

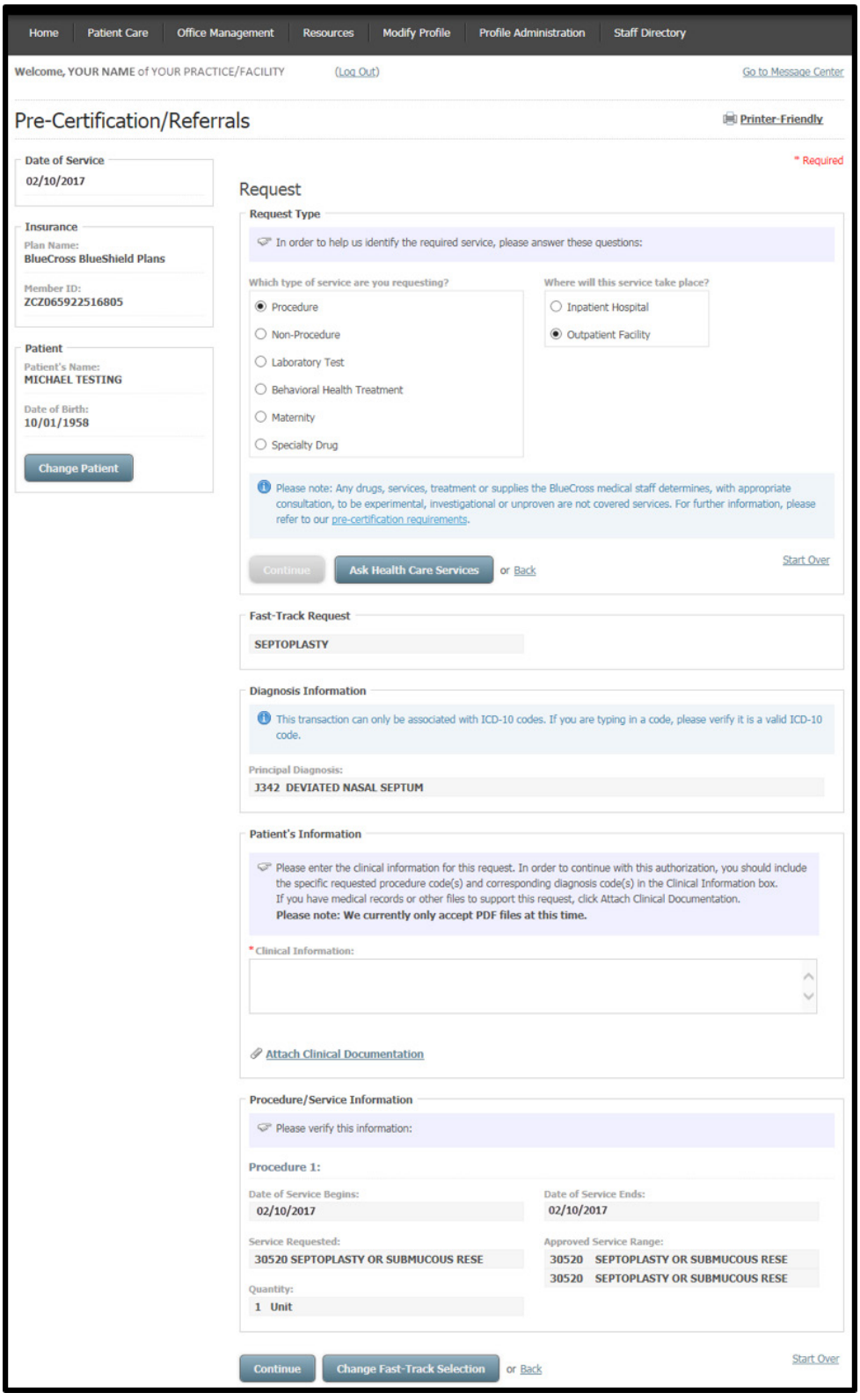
- Procedure – Inpatient Hospital; Outpatient Hospital
- Non-Procedure – Inpatient Hospital; Outpatient Facility; Skilled Nursing Facility; Home*
- Laboratory Test – Independent Lab; Outpatient Facility; Office
- Behavioral Health Treatment – Inpatient Hospital; Outpatient Hospital; Office
- Maternity – Inpatient Facility; Outpatient Facility; Home*
- Specialty Drug – Specialty Drug

Continue. Choose **Ask Health Care Services** for questions about the service request if you are unable to answer using My Insurance Manager or by reviewing the Plan's applicable medical policy and/or clinical guidelines.

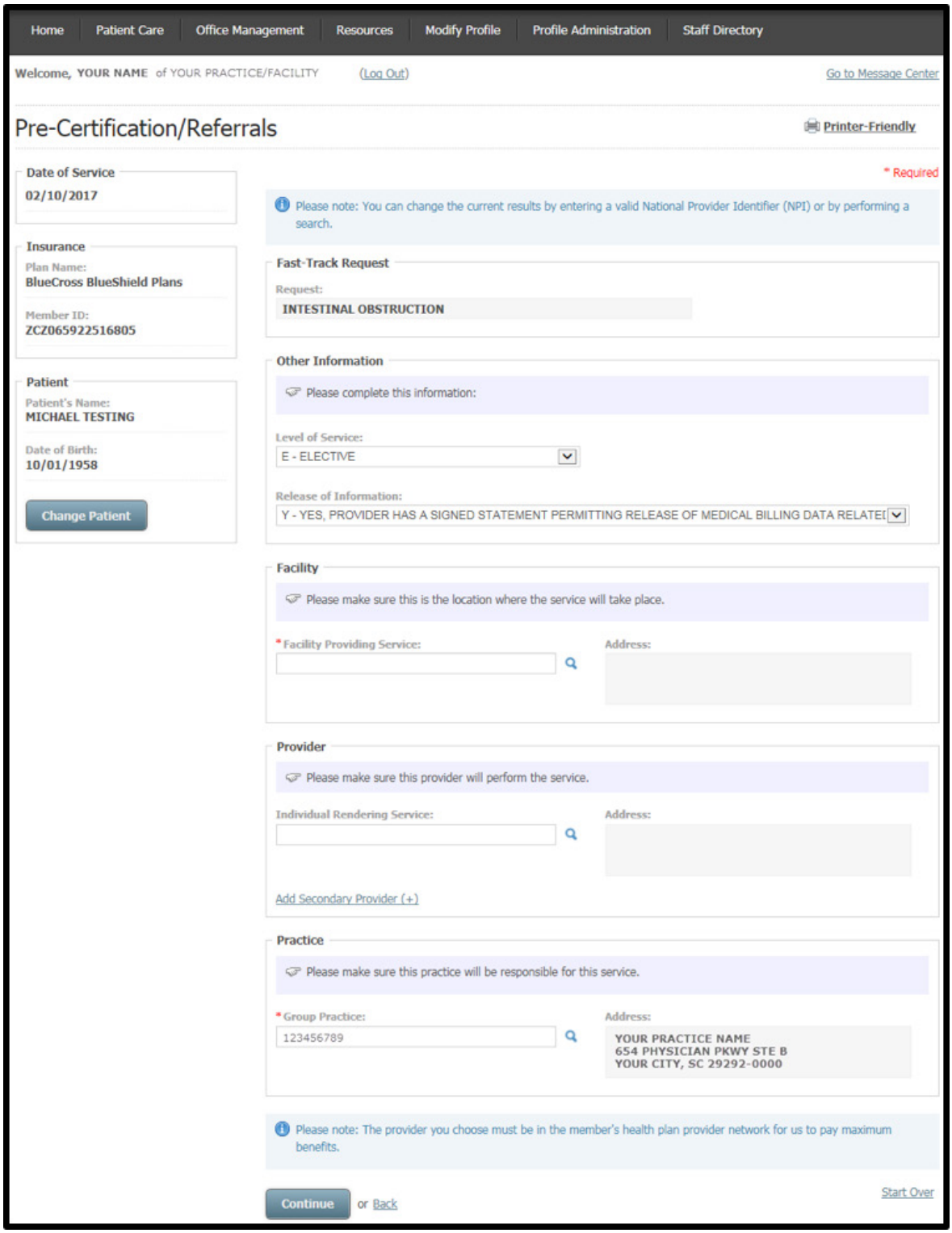
**Not applicable for BlueChoice plans.*



Fast Track Requests will become visible once the request type is determined. The requests are alphabetized. There are numerous results of procedures listed for each letter of the alphabet shown. Click on the appropriate Procedure link or its Detail link to reveal the fast-track selection, diagnosis code and procedure code(s). Place the cursor on the desired procedure to select.



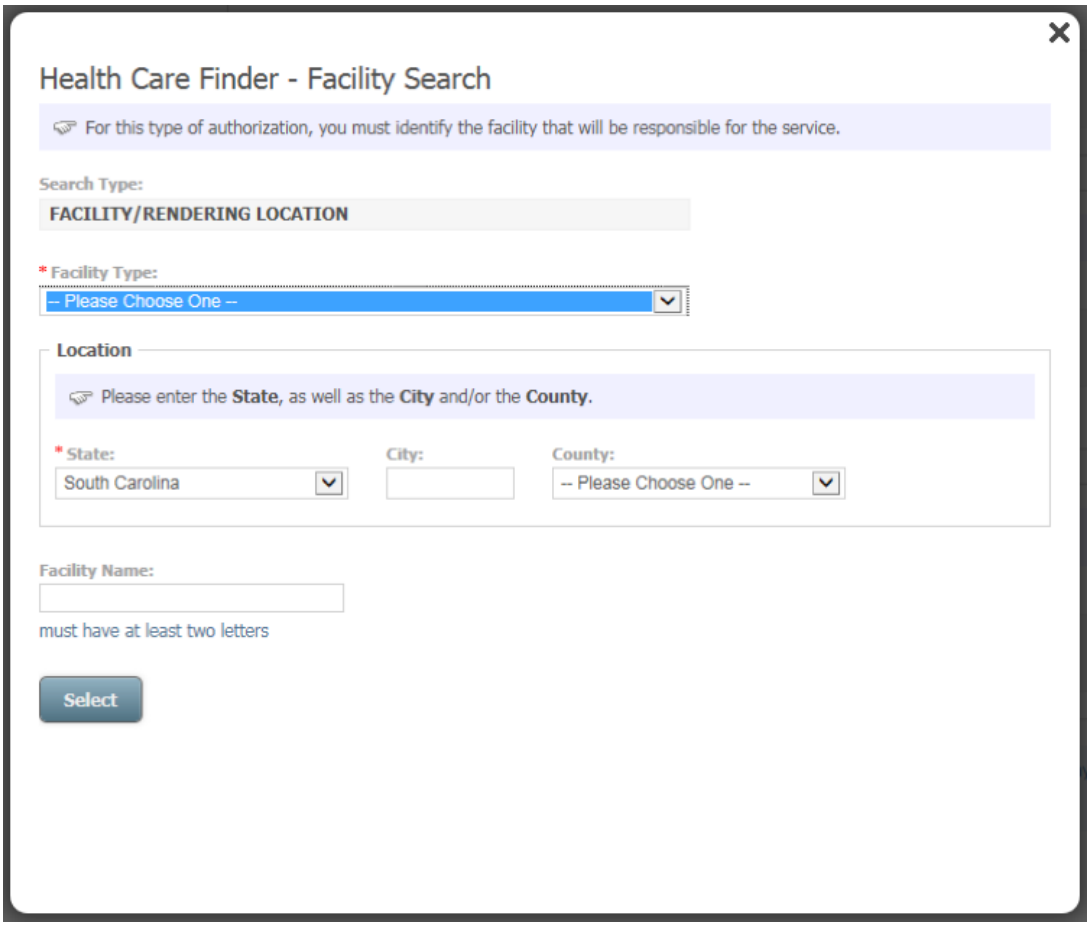
Diagnosis Information will also appear on the screen. Verify information for the service beginning and end dates. Enter Clinical Information in the required field. You can also **Attach Clinical Documentation**. Refer to page 135 for Attach Clinical Documentation instructions. **Continue**; or click **Change Fast-Track Selection** to return to the previous screen.



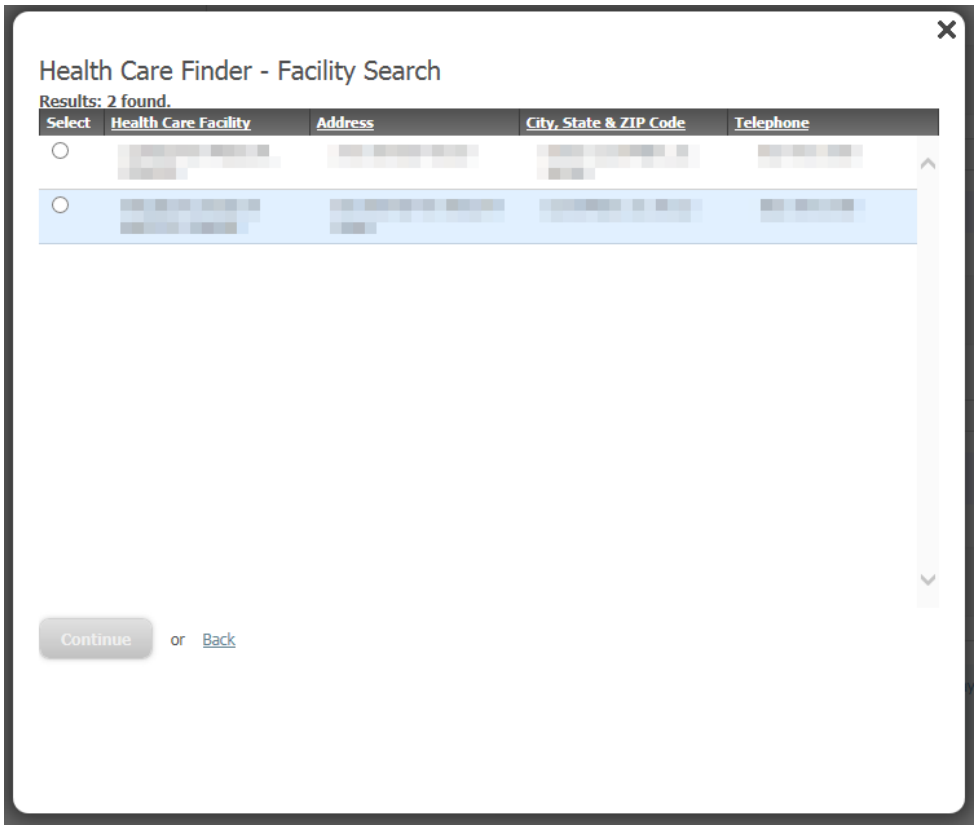
The next screen is Fast-Track Request. It is optional to provide other information in place of the default data for level of service [E-Elective; 03-Emergency; U-Urgent]; release of information (optional); facility providing service; provider(s); and the practice. If you need to choose a different practice location, click the magnifying glass icon to search for other locations affiliated with your account. At the Facility Providing Service field, search for the specific location upon clicking the magnifying glass icon.

If you change the Group Practice, you must select an Individual Rendering Provider in a subsequent screen. The information will then populate in the corresponding fields shown.

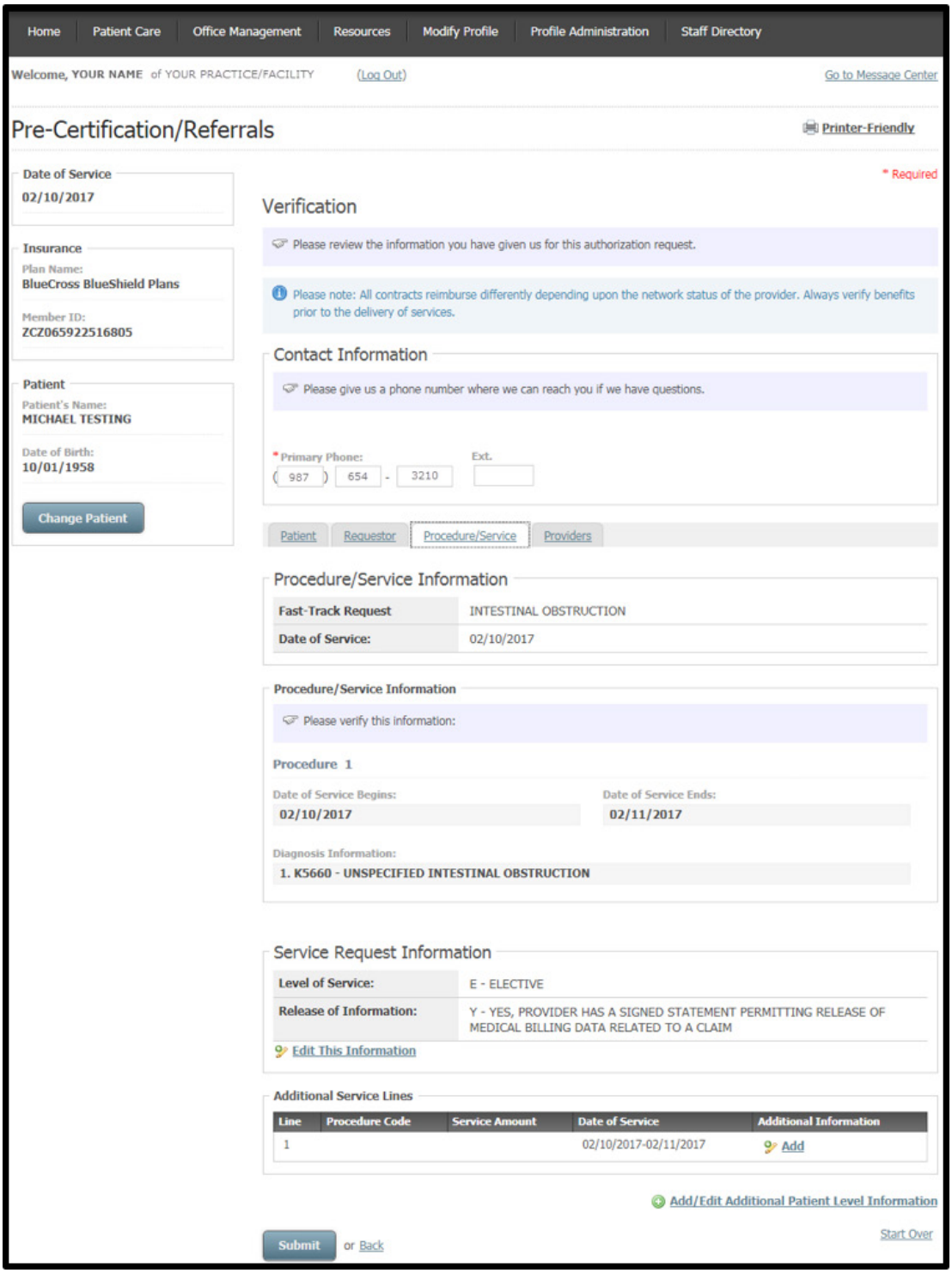
Continue.



From the Health Care Finder – Facility Search screen, designate the facility type and the state where the procedure will be performed. Enter a city or county.



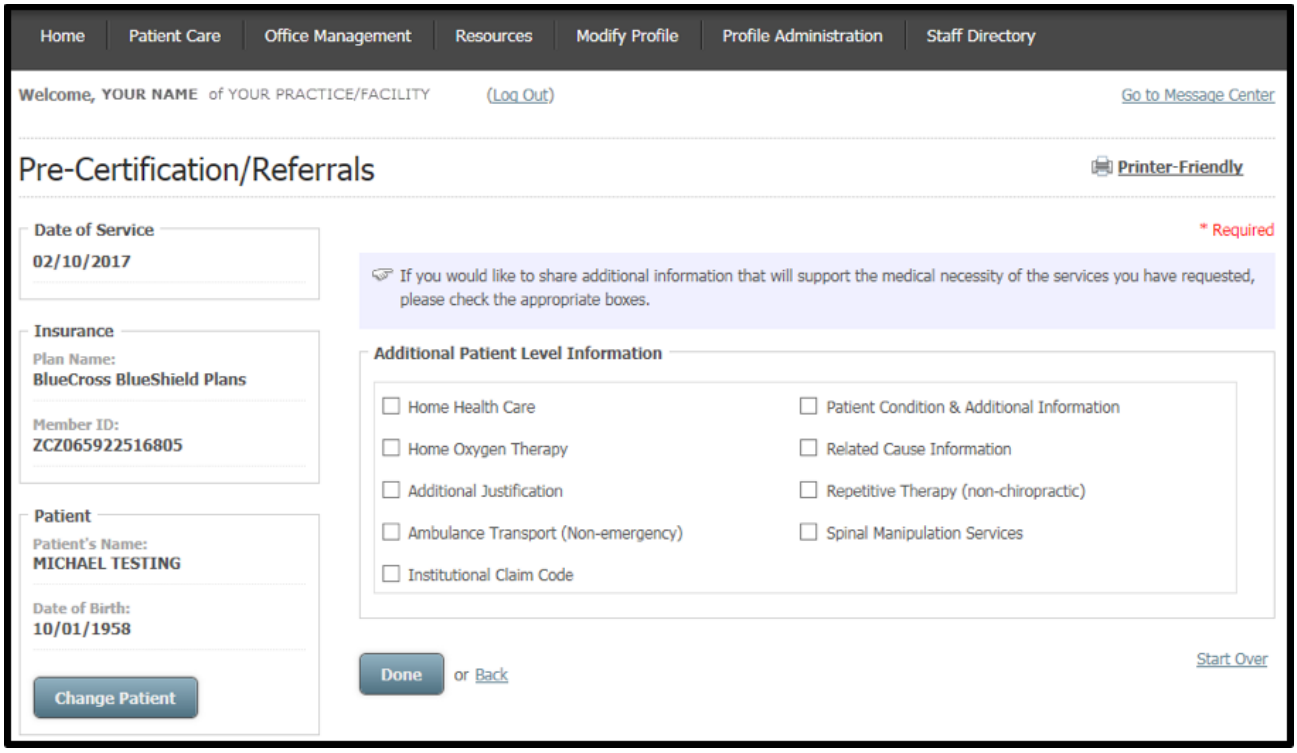
Select a facility from the results that appear from the Health Care Finder – Facility Search screen. **Continue**.



At the Verification screen, you must include the best contact number to be reached in case we have questions about the pre-certification/referral request.

- Follow the **Edit This Information** link to update pre-certification/referral request data.
- From the Procedure/Service tab, you can include other general service level information that will support medical necessity of the services requested in the Additional Service Lines field. Select the corresponding box(es) to include specific additional service level line information for Dental Service Information; Tooth Information; Repetitive Therapy (non-chiropractic); Service Trace Number; and/or Paperwork related to this service. Click **Done** or **Back** to return to the previous screen.

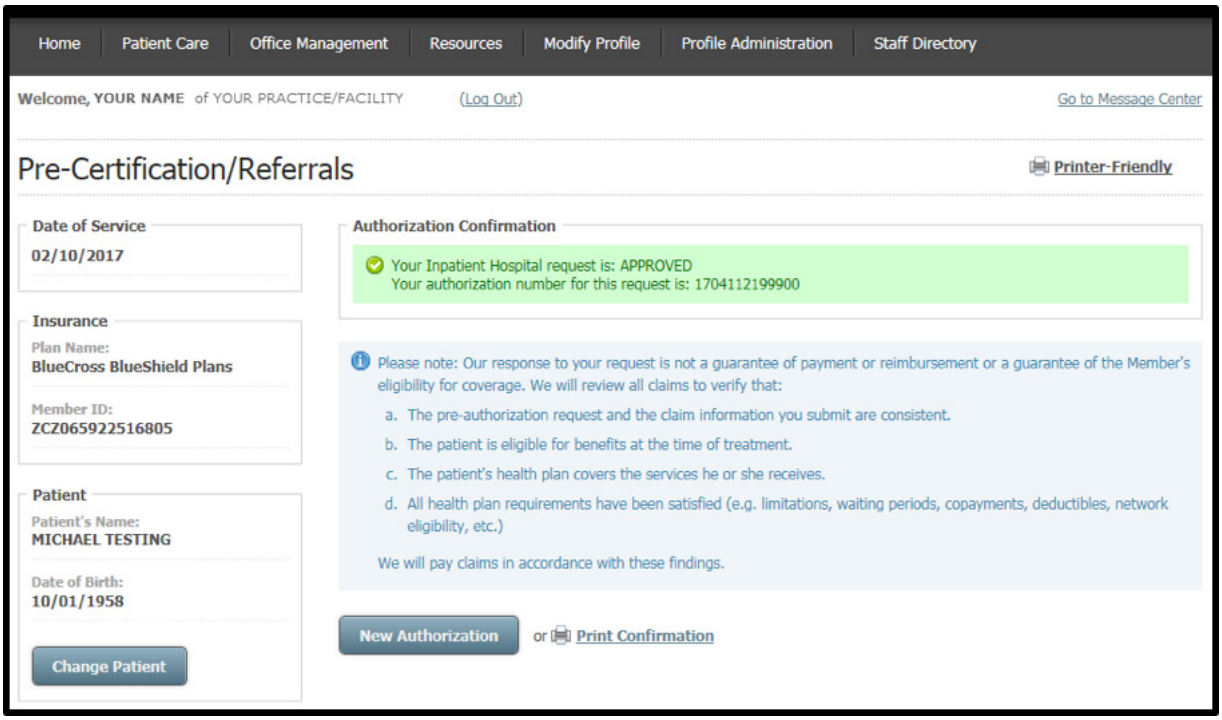
Submit. If you need to review any of the information you entered for the pre-certification request, click on the applicable tabs shown: Patient; Requestor; Procedure/Service; or Providers.

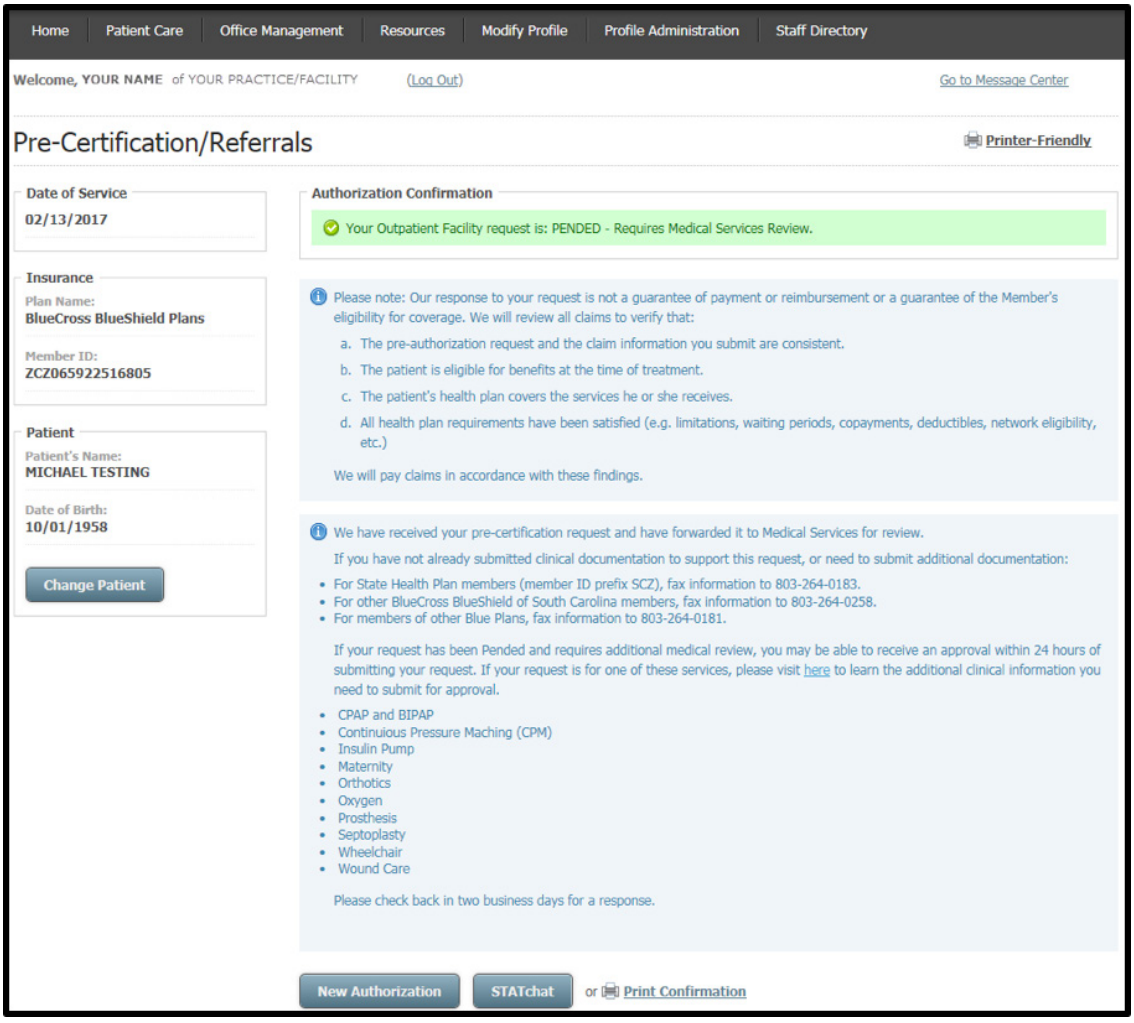


If you select the **Add/Edit Additional Patient Level Information** link, you can share additional information that will support medical necessity of the services requested. Required fields for each option:

- Home Health Care – Prognosis; Home Health Start Date
- Home Oxygen Therapy – Type of Delivery System; Oxygen Flow Rate; Prescribed Equipment 1
- Additional Justification – Activities Permitted; Ambulance Certification; Chiropractic Certification; Functional Limitations; Mental Status; Oxygen Therapy Certification; Durable Medical Equipment
- Ambulance Transport (Non-emergency) – Transport Code; Location Type; Address Line 1; City; State; ZIP
- Institutional Claim Code – Admission Type Code; Admission Source Code; Patient Status Code; Nursing Home Residential Code
- Patient Condition & Additional Information – Prognosis; Current Health Conditions; Onset Illness Date
- Related Cause Information – Related Cause 1
- Repetitive Therapy (non-chiropractic) – Total Number of Treatments Required; Treatments Will Be Administered Every; Treatments Will Occur Over A Total Period of; Delivery of Services Provided on a Calendar Basis Of; Delivery of Services Provided on a Time Basis of
- Spinal Manipulation Services – Complicated Condition

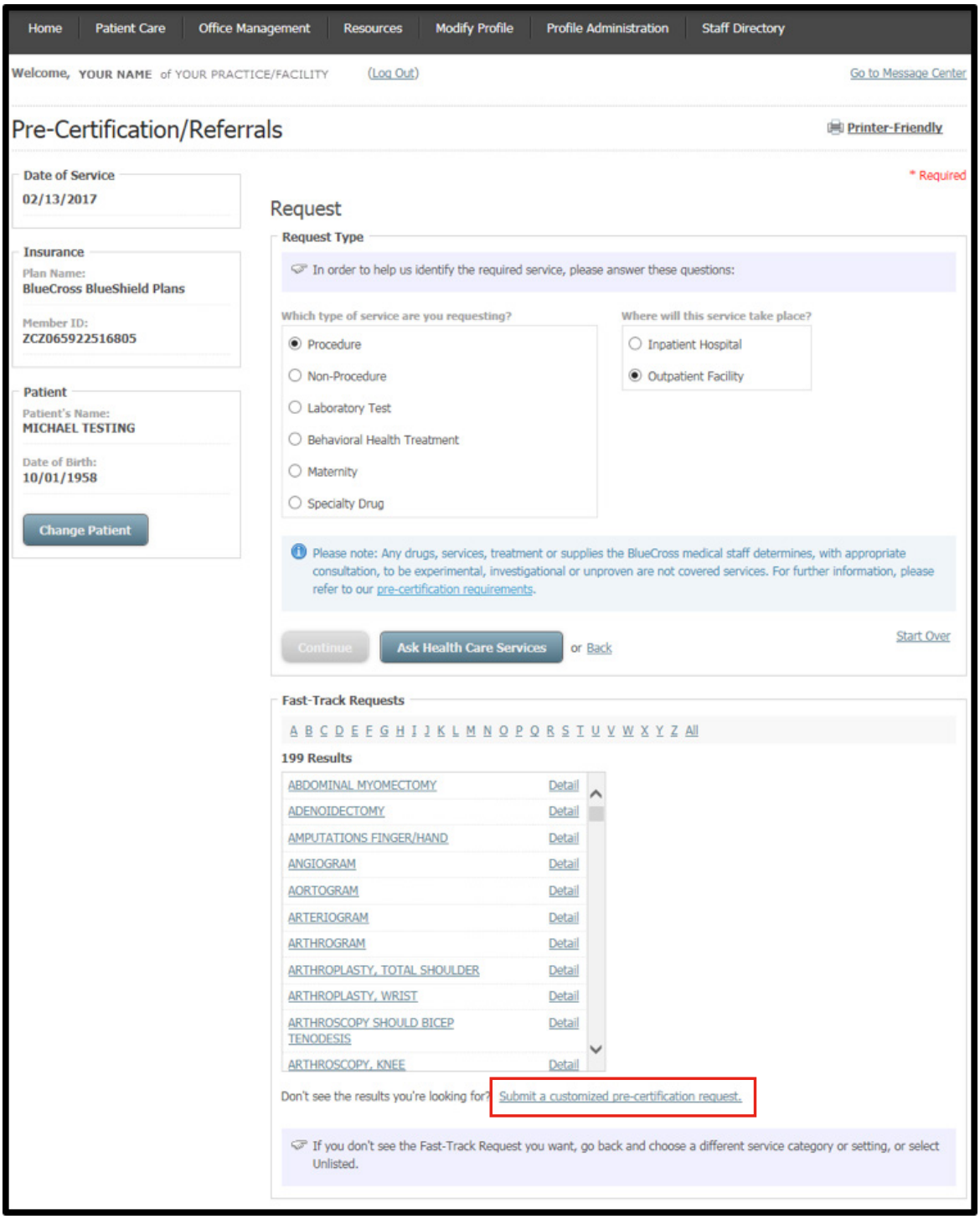
Click **Done** to return to the previous Verification screen. **Submit**.



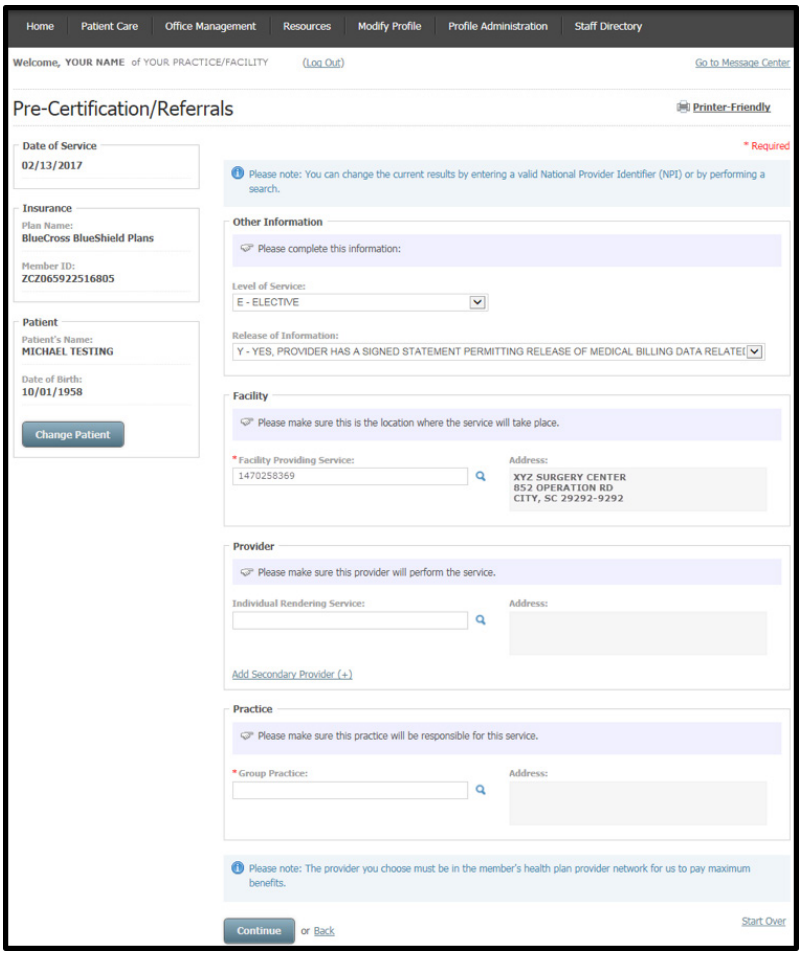


The Authorization Confirmation screen displays the authorization number. The authorization response will also show if the request is approved or has been placed in a pending status for further medical review. You can now create a new authorization, attach clinical document for pended authorizations and/or speak with Provider Services via STATchat.

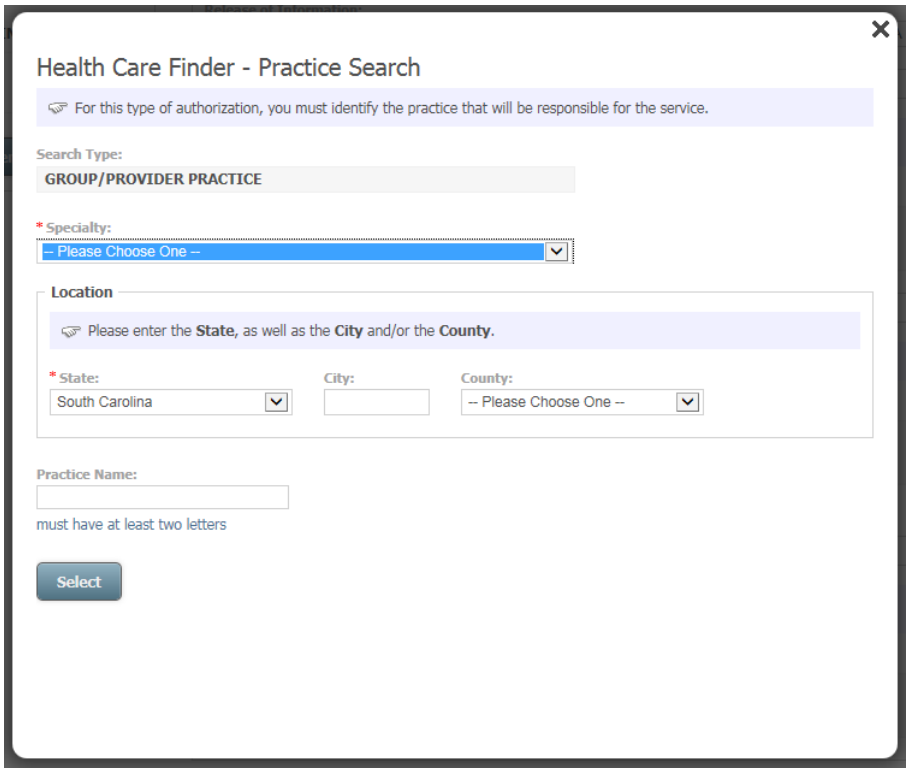
Pre-Certification/Referral – Customized Pre-Certification Request and Clinical Attachment Instruction



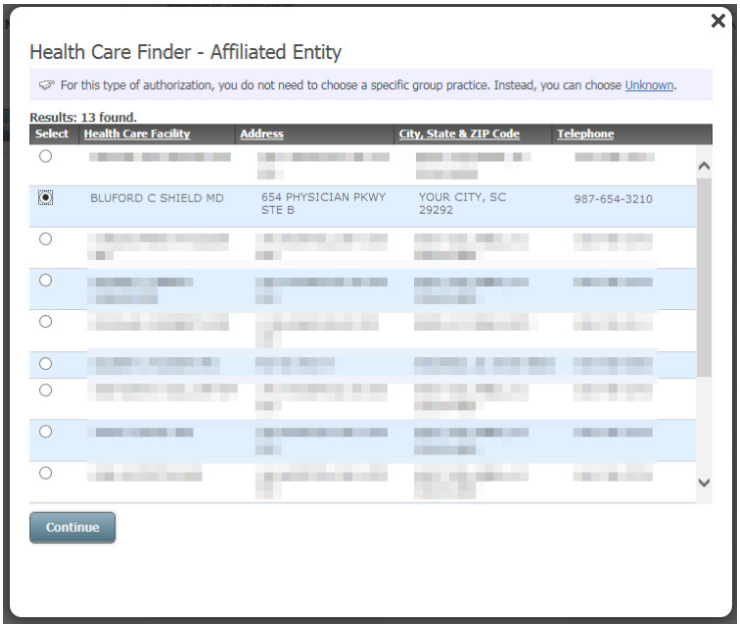
From the Patient Care tab, select Pre-Certification/Referrals. Enter all required patient and location information. At the Request Type screen, choose the type of service and where the service will take place. **Continue**. The Fast-Track Requests field becomes visible after you select the location. Click **Submit a customized pre-certification request**.



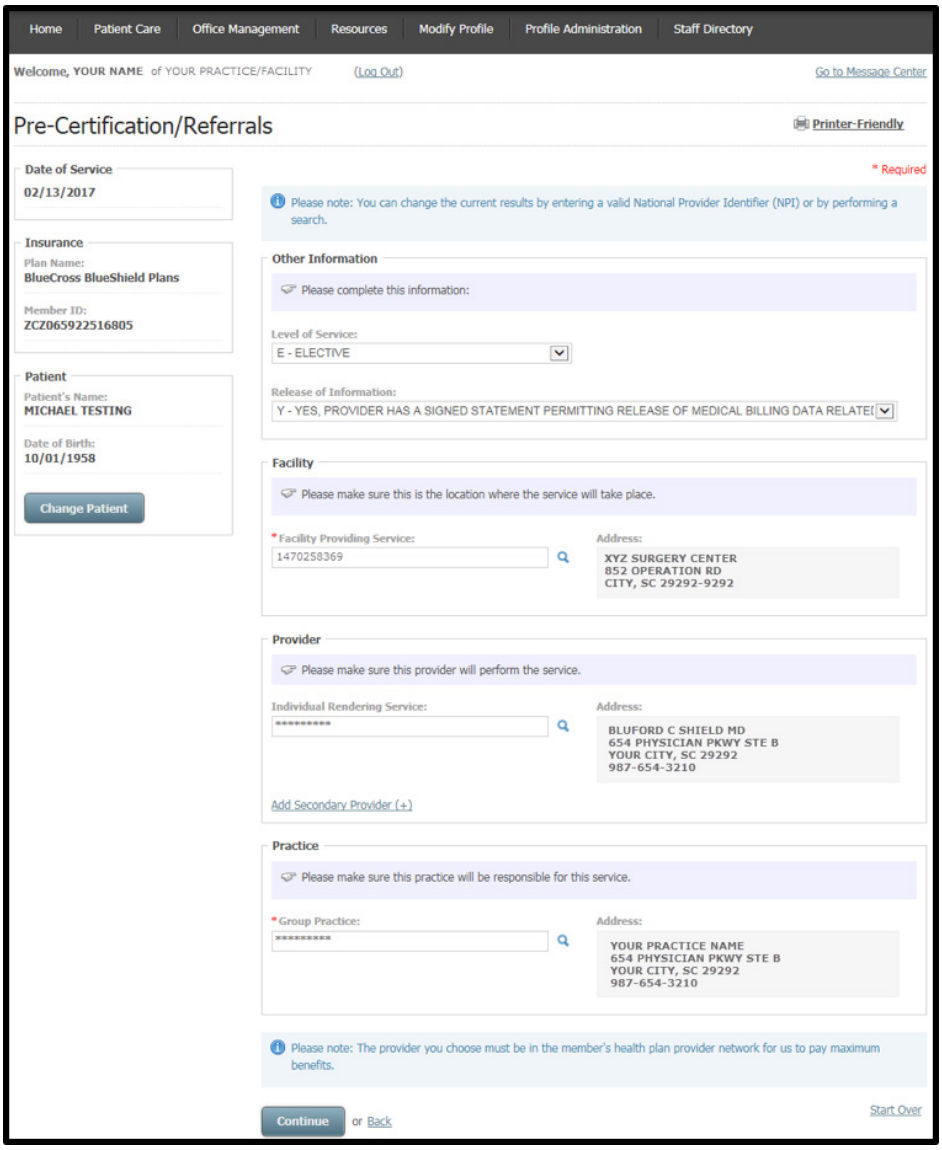
At the Other Information screen, provide additional information for level of service [E-Elective; 03-Emergency; U-Urgent]; release of information; facility providing service; provider(s); and the practice.



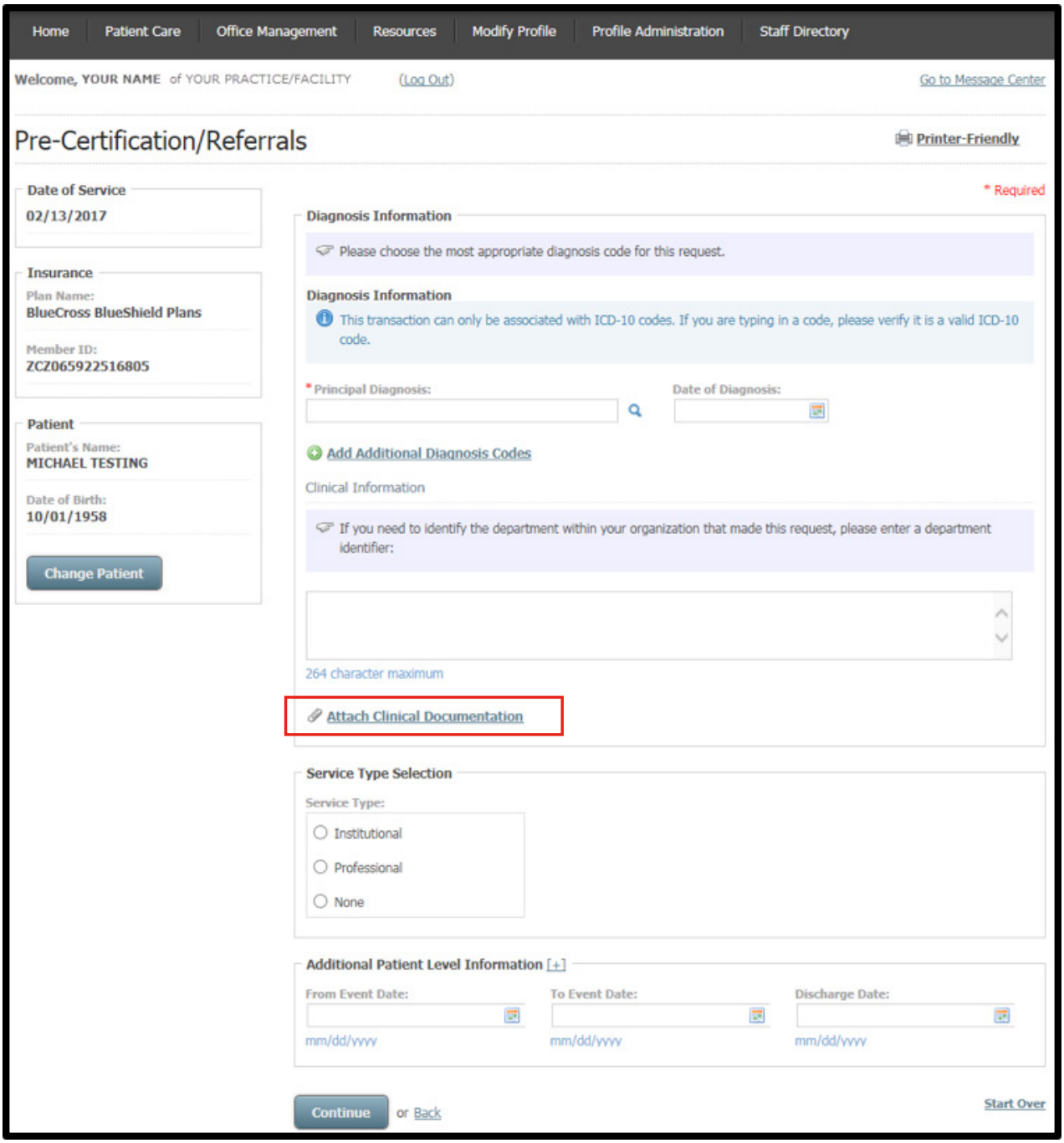
The Health Care Finder – Practice Search screen appears when you select the Practice magnifying glass icon. Identify the practice that will be responsible for the service. **Select**.



The Health Care Finder – Affiliated Entity screen appears after you designate the practice responsible for the service. Select the facility and **Continue**.



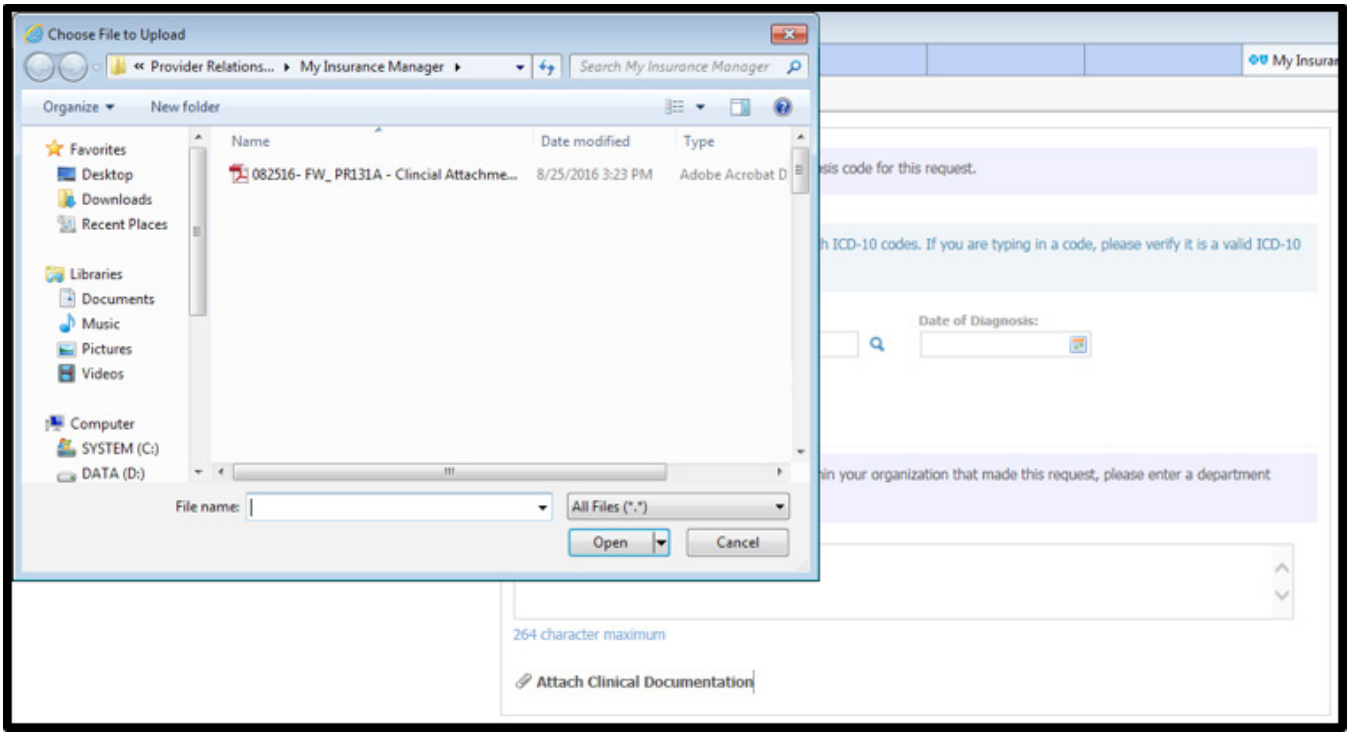
Note all required fields have been updated with selections from secondary screens. **Continue**.



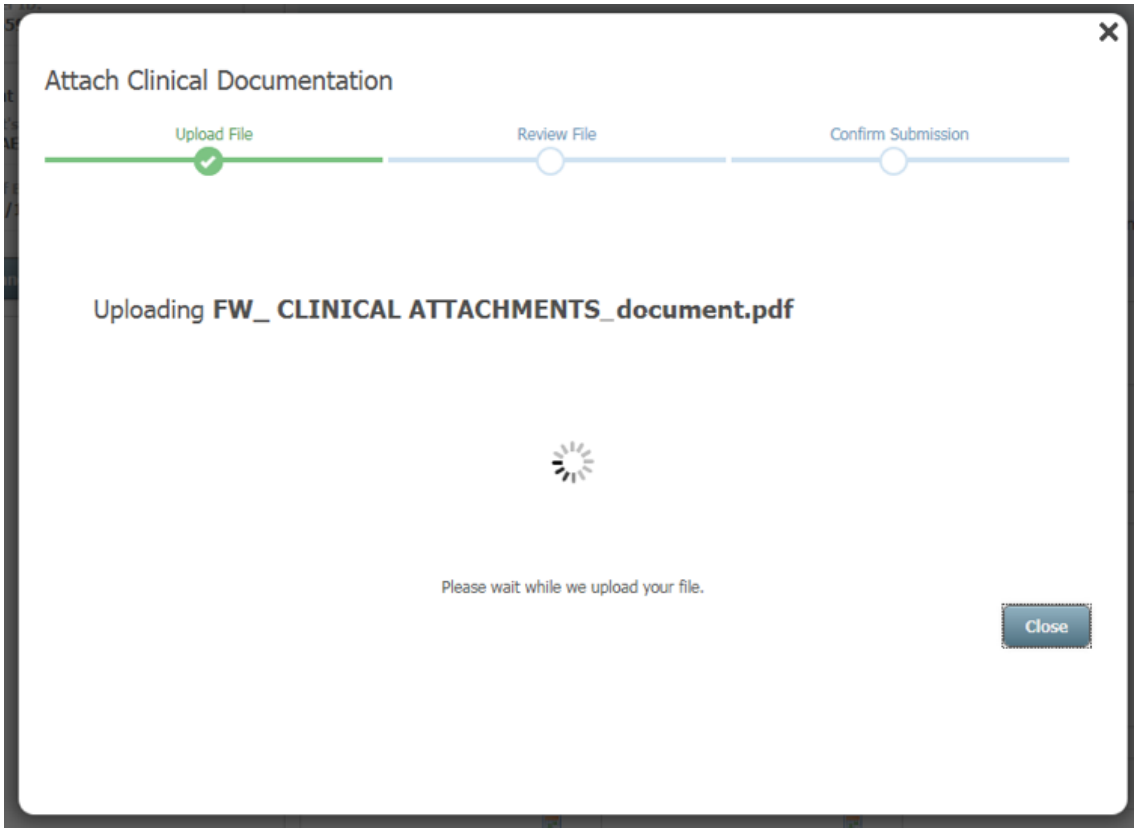
The Diagnosis Information screen is next in the customized pre-certification request process. At Principal Diagnosis field, enter the appropriate ICD-10 diagnosis code without including a decimal. You can also search for the specific diagnosis code by clicking the magnifying glass icon.

- When you choose Institutional for the Service Type Selection, the view expands to show required entries for Procedure Code Type and Code.
- When you choose Professional for the Service Type Selection, the view expands to show required entries for Procedure Code Type; Code and Primary Diagnosis.
- When appropriate, select **Attach Clinical Documentation** to add medical information or other files to support the pre-certification/referral request. This link will not appear unless the procedure requires clinical documentation.

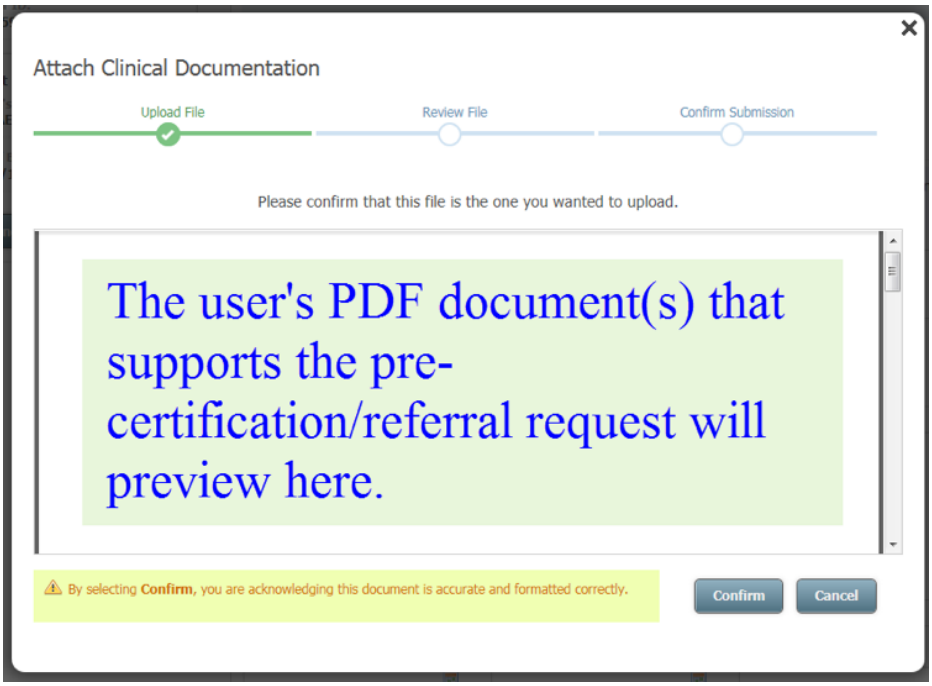
Continue. Follow the process through Verification and Authorization Confirmation screens.



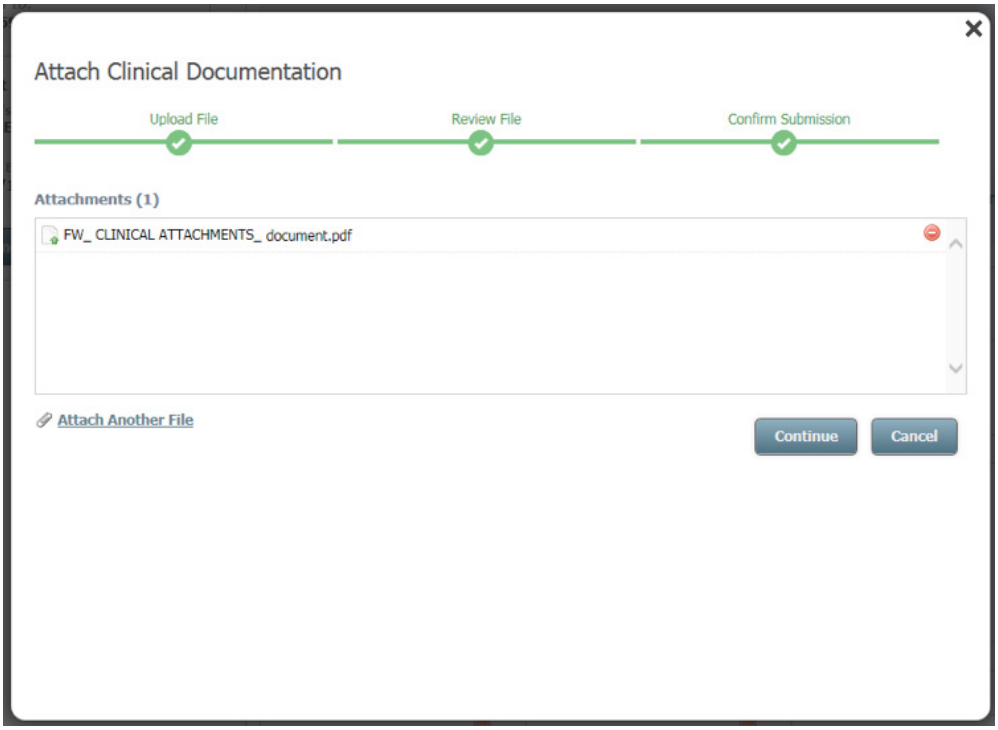
Choose a file [up to 10 documents] to attach. The file must be in PDF format with a maximum of 30 MB. Select **Open**.



This screen will appear when the file begins to upload to My Insurance Manager. If the file is invalid [i.e., a non-PDF file or one that exceeds 30 MB], you will receive this error message: the file type selected cannot be accepted; please try another type.

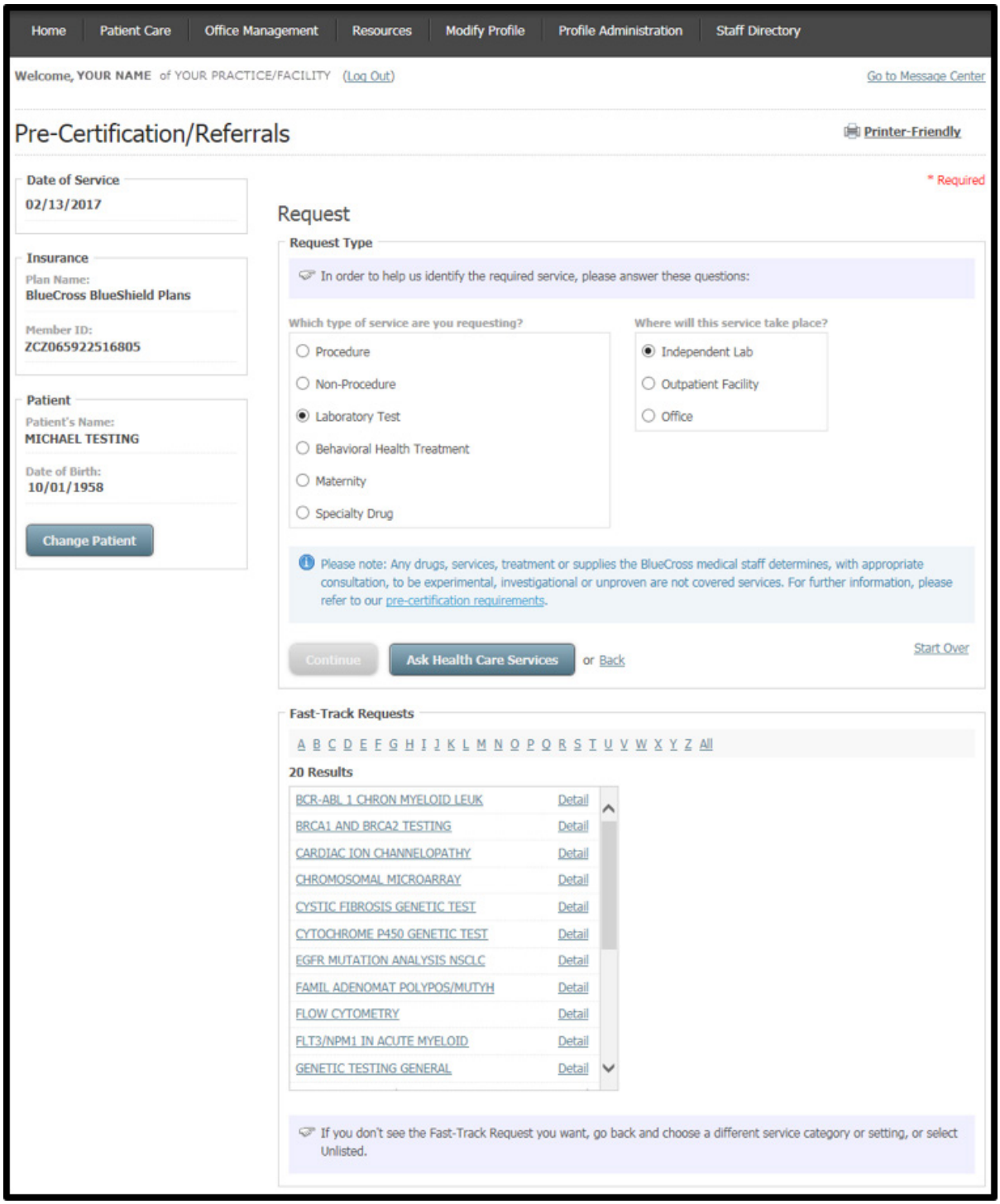


You can see a preview of the selected document during upload. Once you select **Confirm**, you will not be able to go back and view what was uploaded.



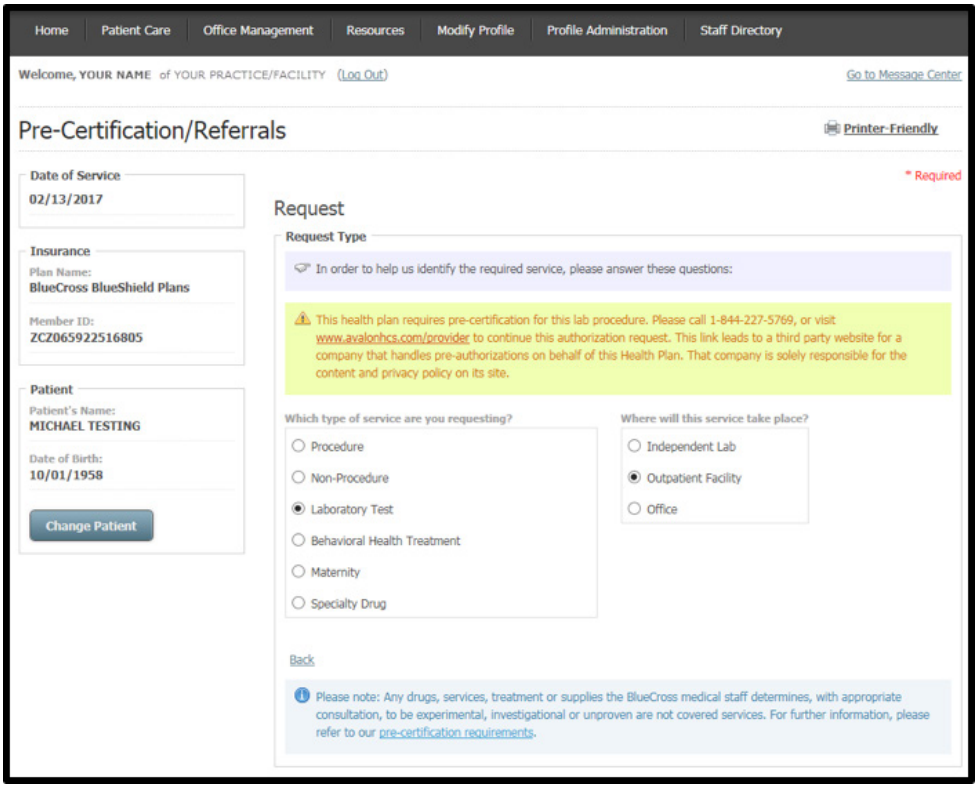
Review and confirm that this is the file you want to upload. You can choose to **Attach Another File**. You can abandon the clinical attachment process by clicking **Cancel**. To remove an attached document, select the red minus [-] button. **Continue**.

Pre-Certification/Referral – Laboratory Instruction



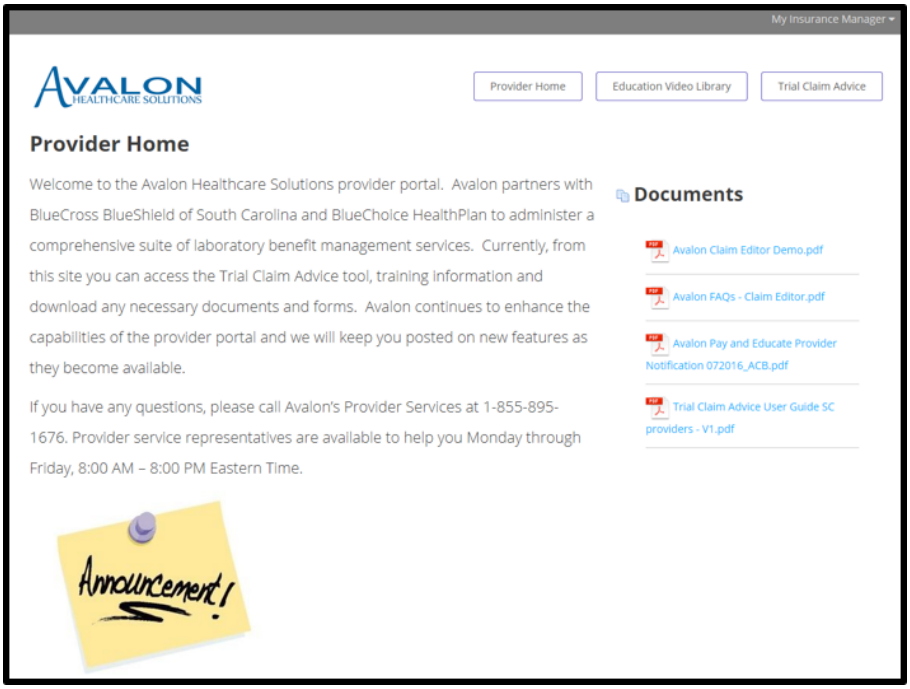
From the Patient Care tab, select Pre-Certification/Referrals. Enter all required patient and location information. At the Request Type screen, choose Laboratory Test as the service type and where the service will take place. **Continue**.

You will see the Fast-Track Requests field after you select the location. Place the cursor on the desired procedure to select.



A message appears alerting you of special pre-certification/referral requirements for the selected service. Laboratory procedures that require pre-certification must be authorized via Avalon Healthcare Solutions (Avalon*). Call 844-227-5769 to continue. Click the link www.avalonhcs.com/provider for additional information about laboratory pre-certification via Avalon.

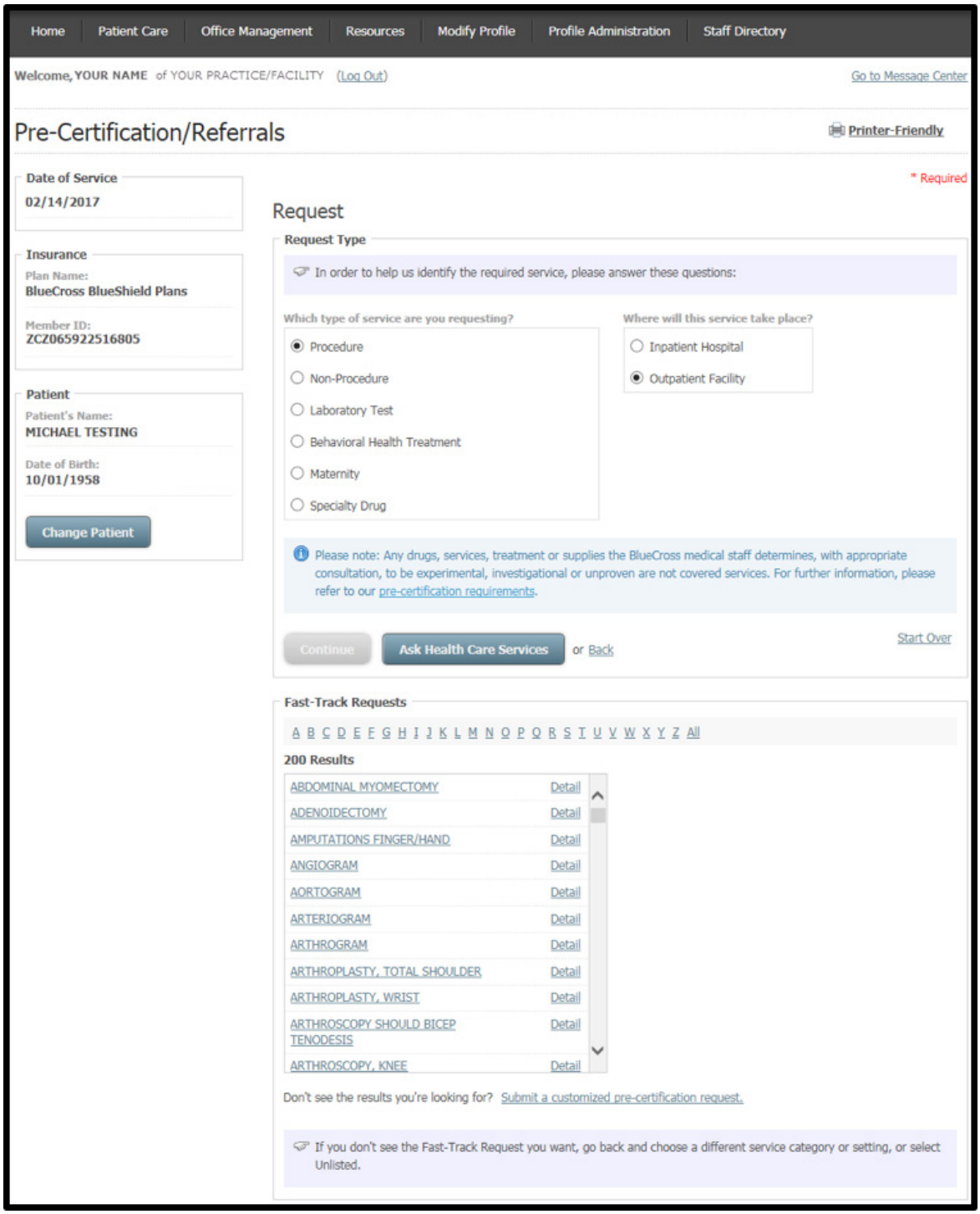
*Avalon is an independent company that provides laboratory benefit management services on behalf of BlueCross and BlueChoice.



This screen appears when you follow the link to Avalon's website.

To fax a pre-certification/referral request to Avalon, use the Avalon Preauthorization Request Form. Find this form on the Lab Precertification page in the Providers section of our websites at web.southcarolinablues.com/providers/educationcenter/precertification/labprecertification.aspx or www.bluechoicesc.com/providers/educationcenter/providerresources/labprecertification.aspx.

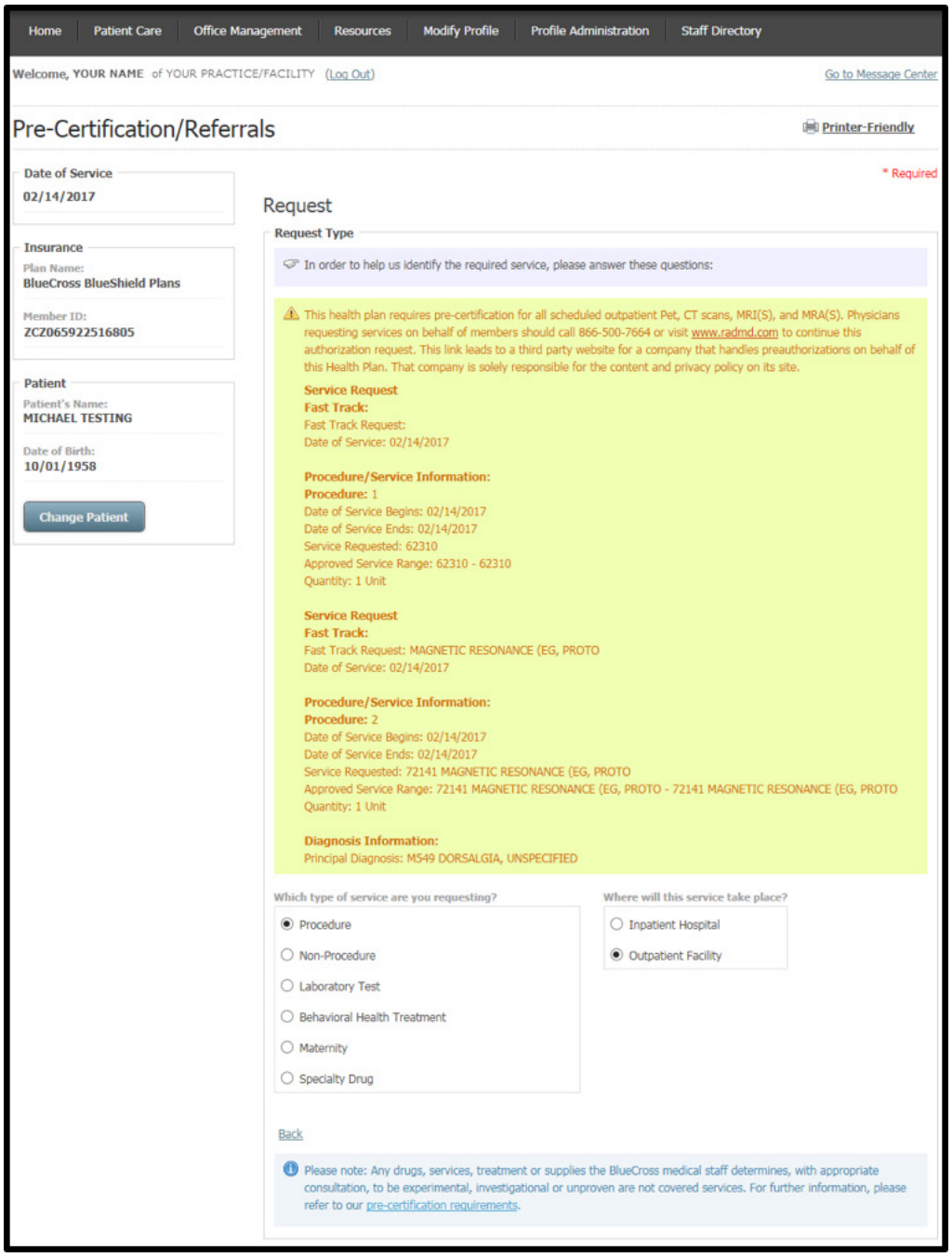
Pre-Certification/Referral – Radiology; Radiation Oncology; Musculoskeletal Care; Nuclear Cardiology Instruction



From the Patient Care tab, select Pre-Certification/Referrals. Enter all required patient and location information. At the Request Type screen, choose the type of service and where the service will take place. **Continue**.

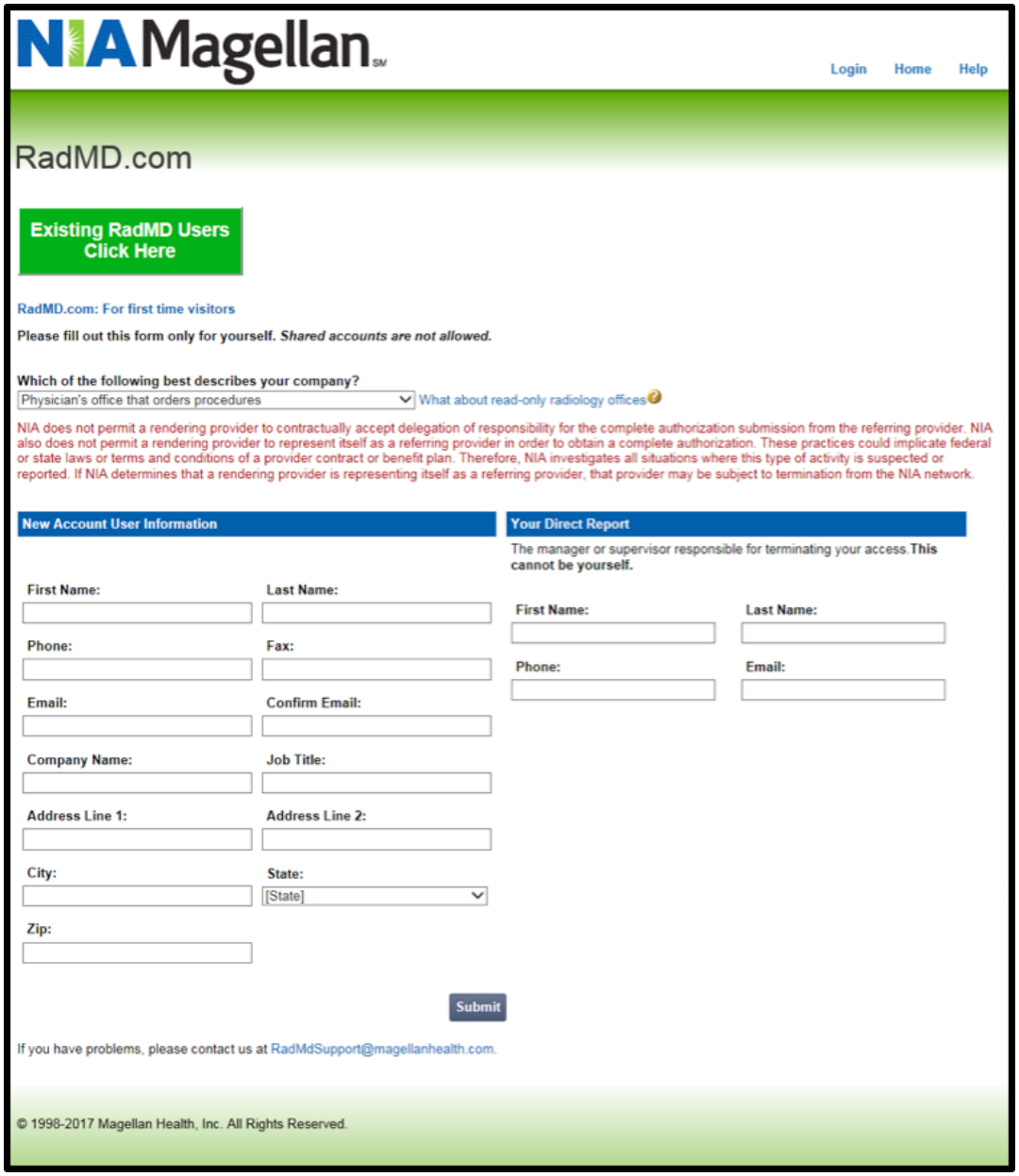
You will see the Fast-Track Requests field after you have selected the location. Place the cursor on the desired procedure to select.

- There are only Radiology fast-track options for BlueCross and BlueChoice plans.
- There are no Radiation Oncology or Musculoskeletal Care fast-track options for BlueCross and BlueChoice plans.



A message appears alerting you of special pre-certification/referral requirements for the selected service. Advanced radiology procedures that require pre-certification must be authorized via National Imaging Associates (NIA*) Magellan's website. Call 866-500-7664 or click the link www.radmd.com to continue radiology pre-certification via NIA Magellan.

*NIA Magellan is an independent company that handles authorization for certain imaging services on behalf of BlueCross and BlueChoice.



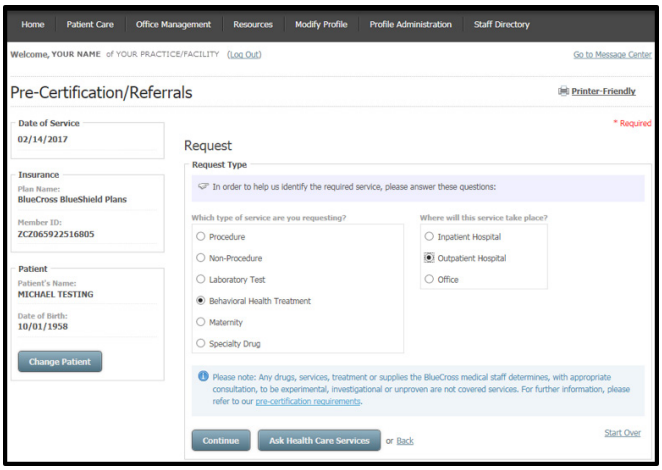
This screen appears when you follow the link to NIA Magellan's provider portal. Existing users may access the site via the green button. First-time users must complete required fields to create an account. Select the response that best describes your company [physician office that orders procedures; physician office that orders radiation cardiology procedures]. **Submit**.

A subsequent screen gives Menu Options and Account Information. Choose a Request link to be routed to the appropriate service type:

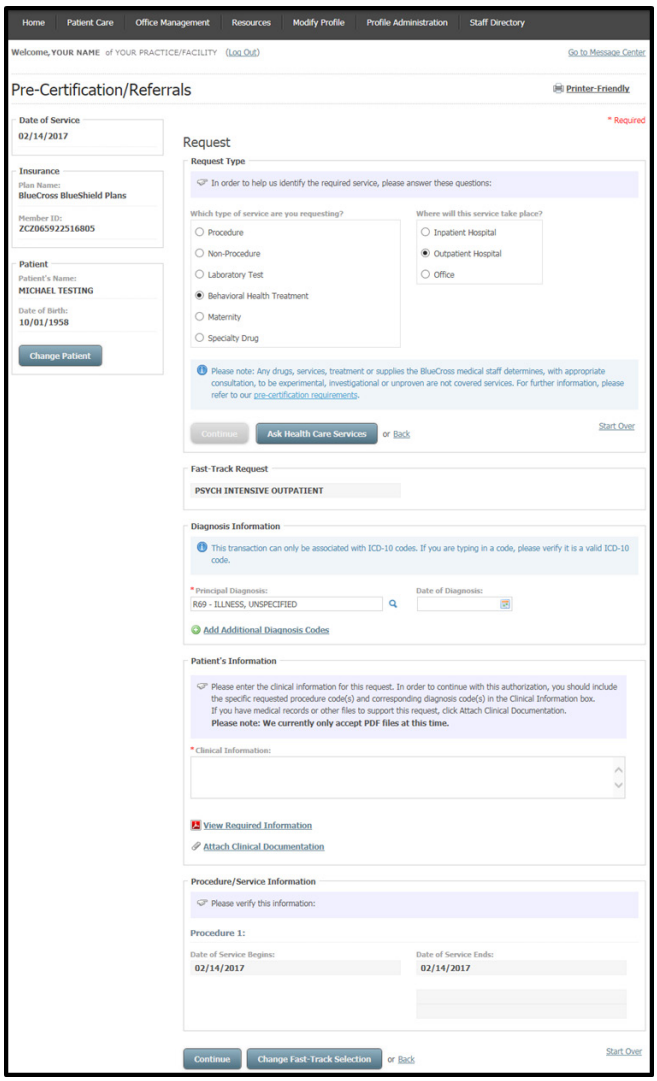
- Request an Exam – Advanced Radiology Services
- Request Physical Medicine – Physical Medicine Services
- Request a Radiation Treatment Plan – Radiation Oncology Services
- Request Pain Management or Minimally Invasive Procedure – Musculoskeletal Care Management
- Request Spine Surgery or Orthopedic Surgery – Musculoskeletal Care Management

Follow the NIA Magellan pre-certification process through subsequent screens to complete.

Pre-Certification/Referral – Behavioral Health Instruction

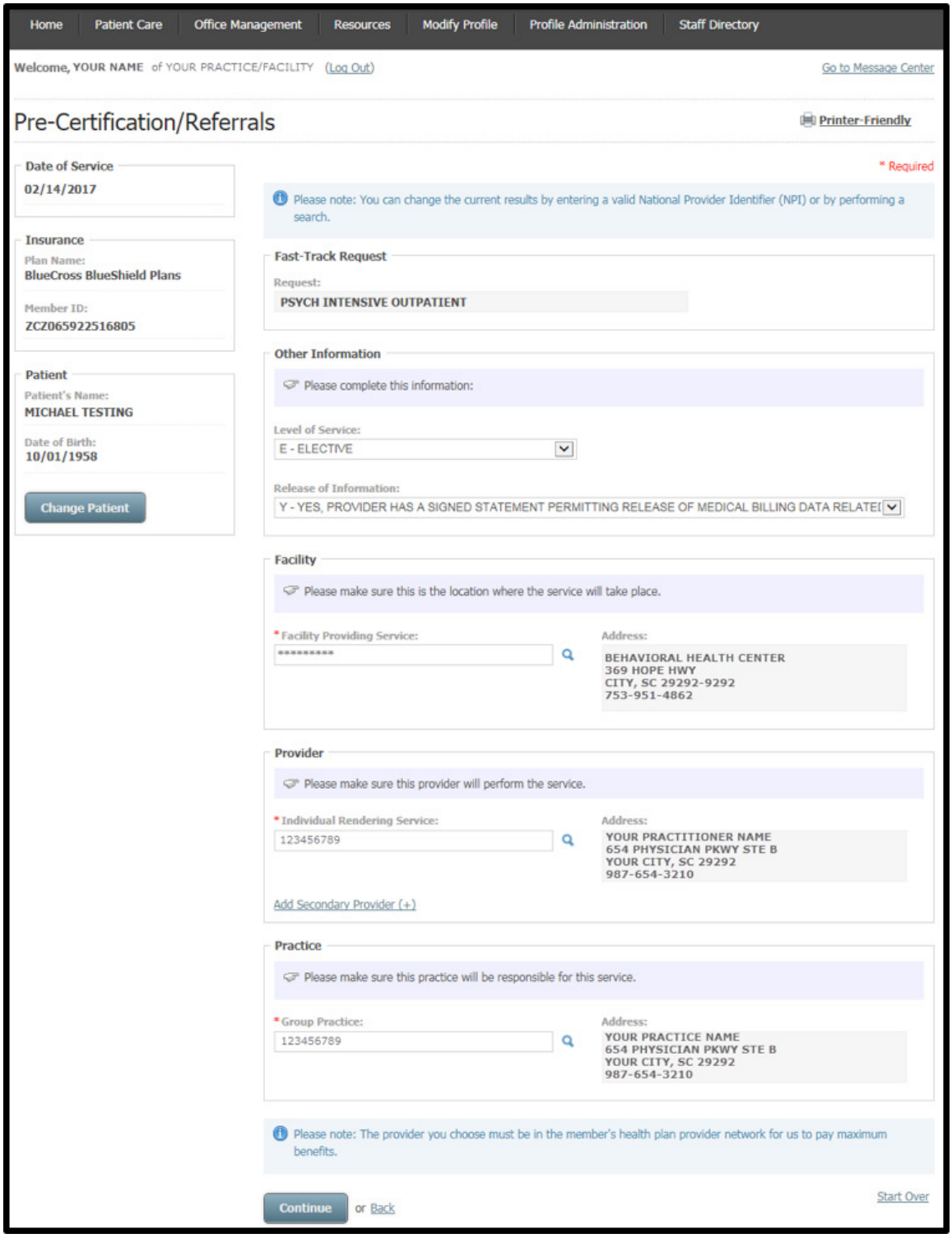


From the Patient Care tab, select Pre-Certification/Referrals. Enter all required patient and location information. At the Request Type screen, choose Behavioral Health Treatment as the type of service, and where the service will take place. **Continue**.



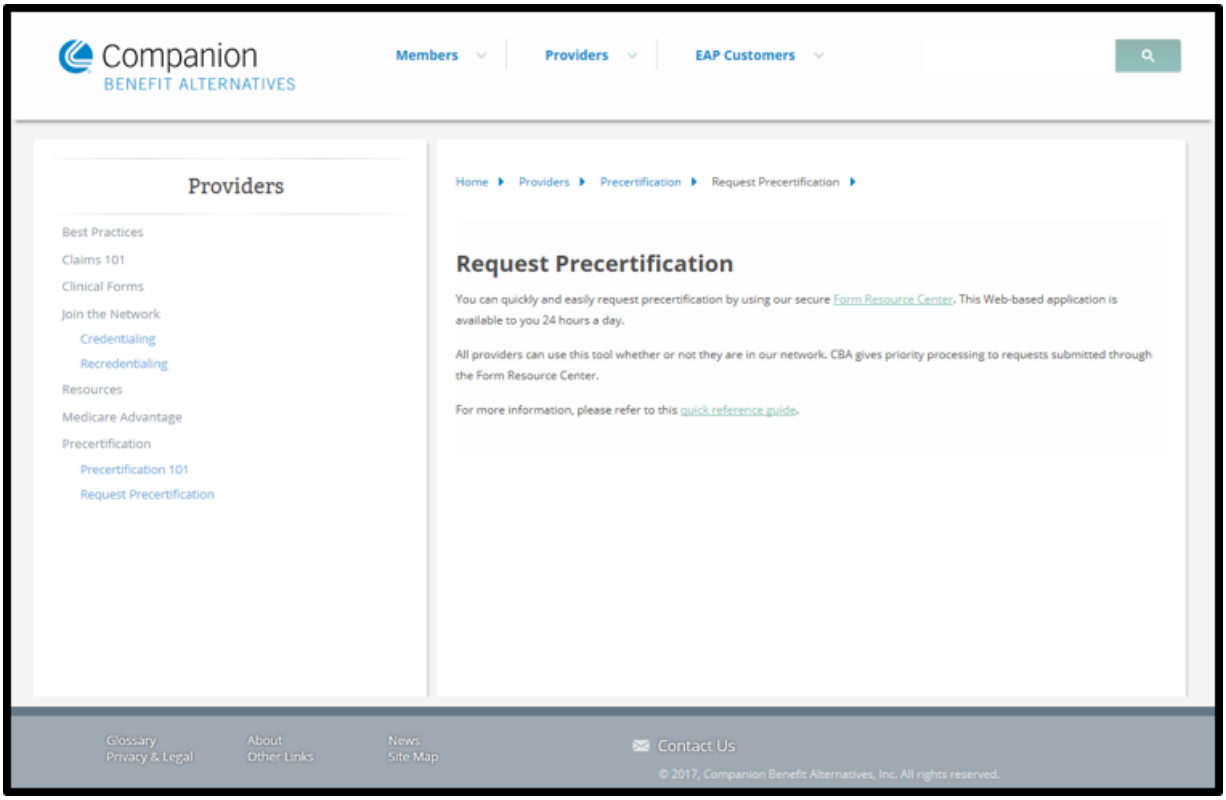
You will see the Fast-Track Requests field after you select the location. Place the cursor on the desired procedure to select.

Diagnosis Information, Patient's Information and Procedure/Service Information appear on the screen. Enter Clinical Information and **Attach Clinical Documentation** as appropriate. Verify the service beginning and end dates. **Continue**. Click **Change Fast-Track Selection** if you need to return to the previous screen.



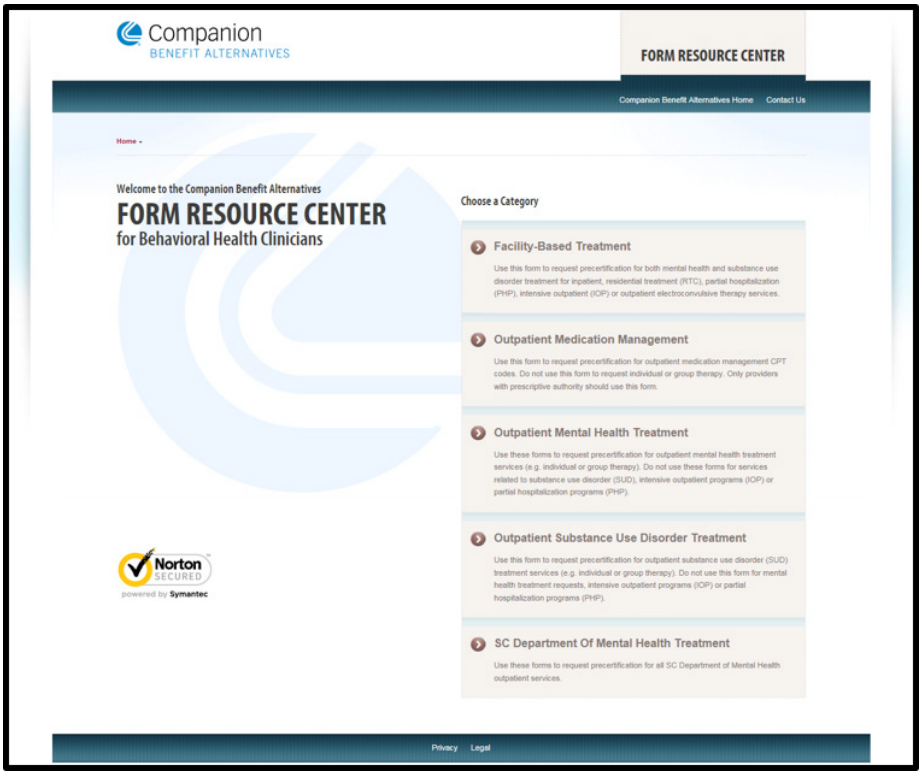
At the Other Information screen, provide additional information for level of service [E-Elective; 03-Emergency; U-Urgent]; release of information; facility providing service; provider(s); and the practice.

Continue. Follow the process through Verification and Authorization Confirmation screens.



Certain behavioral health services require online pre-certification via the Companion Benefit Alternatives (CBA*) website. Call 800-868-1032 or visit the Provider page of www.CompanionBenefitAlternatives.com to continue.

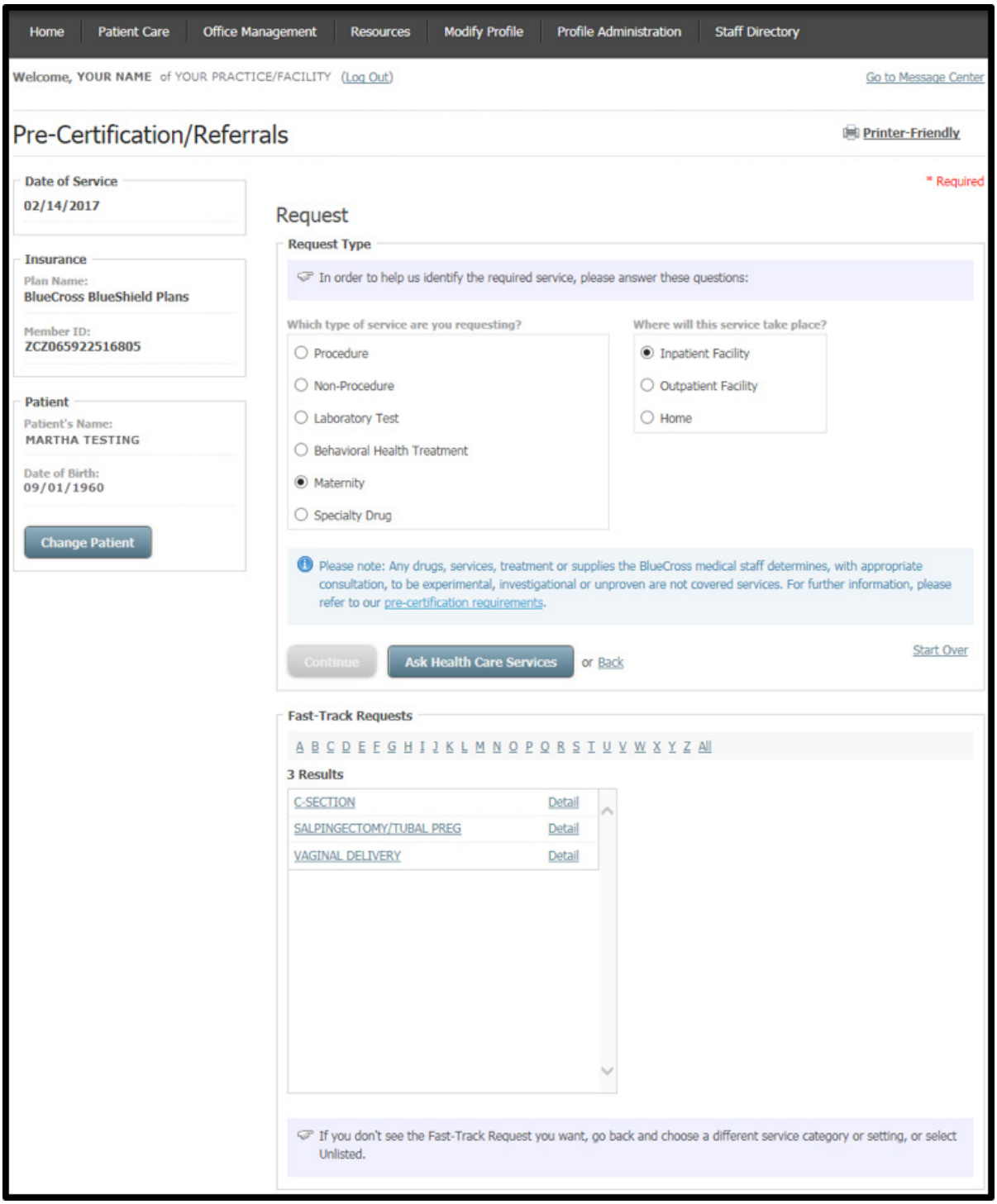
*CBA is a behavioral health managed care company that handles behavioral health care services on behalf of BlueCross and BlueChoice.



From the secure Form Resource Center page, you can easily complete web-based applications for Facility-Based Treatment; Outpatient Medication Management; Outpatient Mental Health Treatment; Outpatient Substance Use Disorder Treatment; and/or SC Department of Mental Health Treatment.

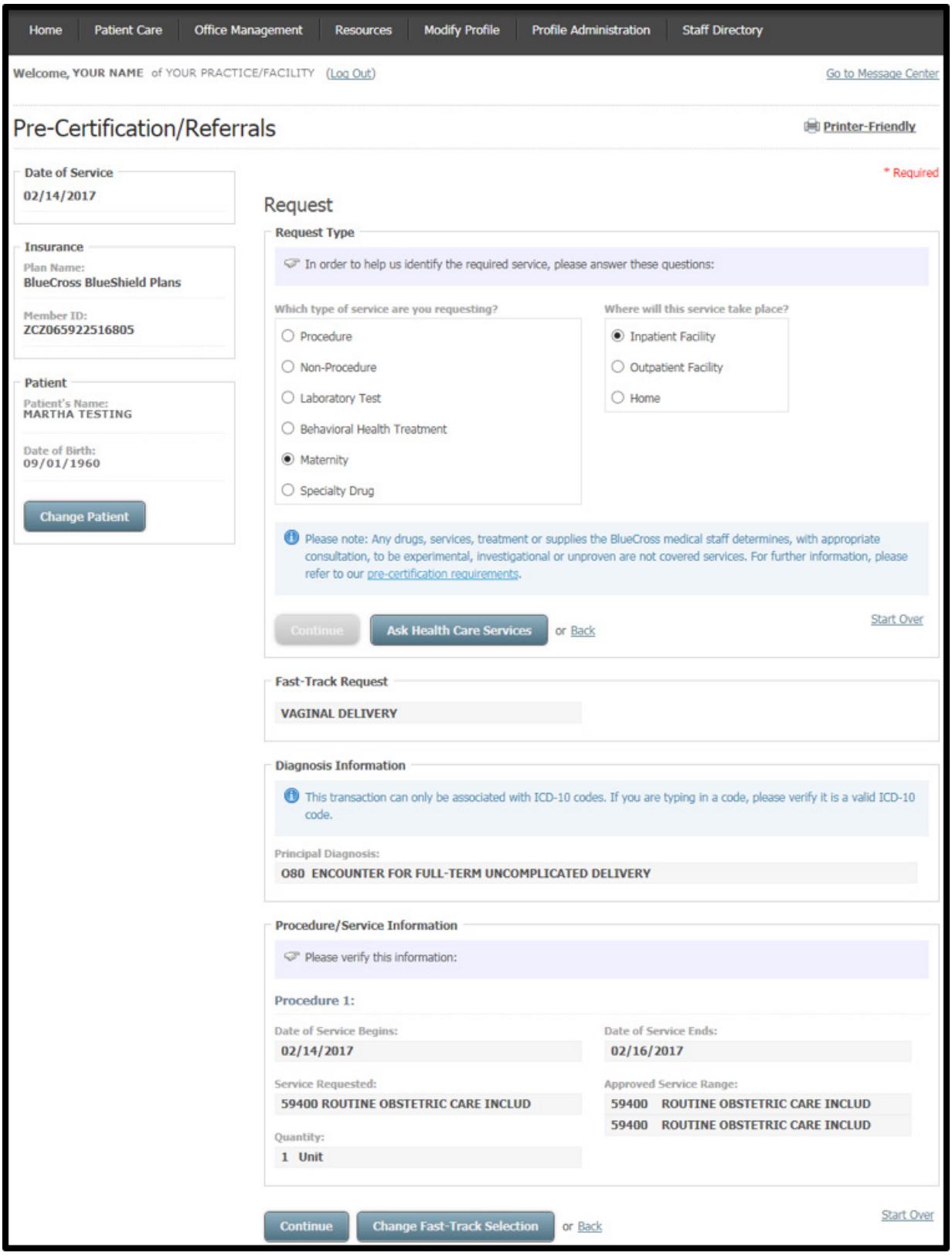
- To request pre-certification for psychological testing, contact CBA to request the appropriate form.

Pre-Certification/Referral – Maternity Instruction

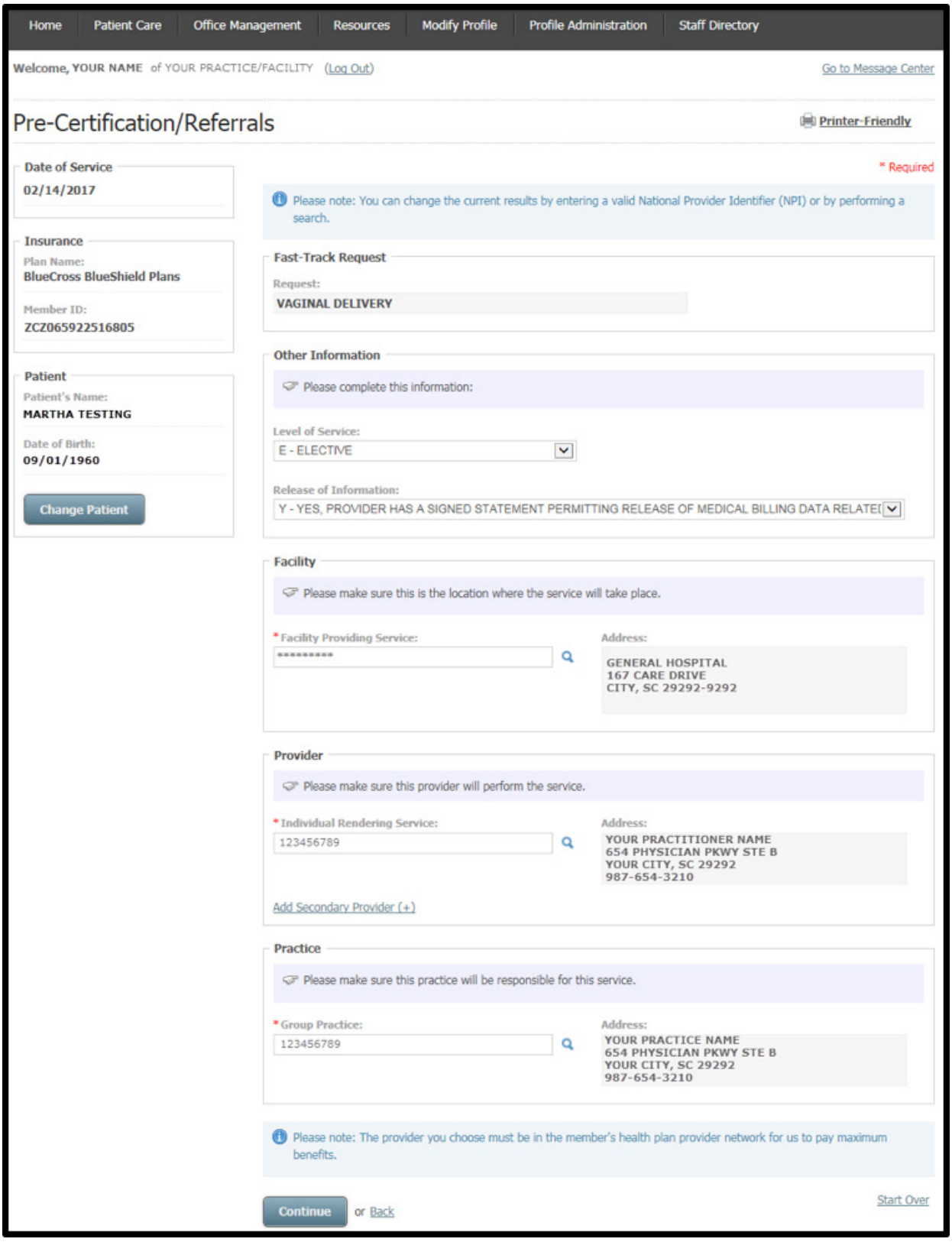


From the Patient Care tab, select Pre-Certification/Referrals. Enter all required patient and location information. At the Request Type screen, choose Maternity as the type of service, and where the service will take place. **Continue**.

You will see the Fast-Track Requests field after you select the location. Place the cursor on the desired procedure to select.



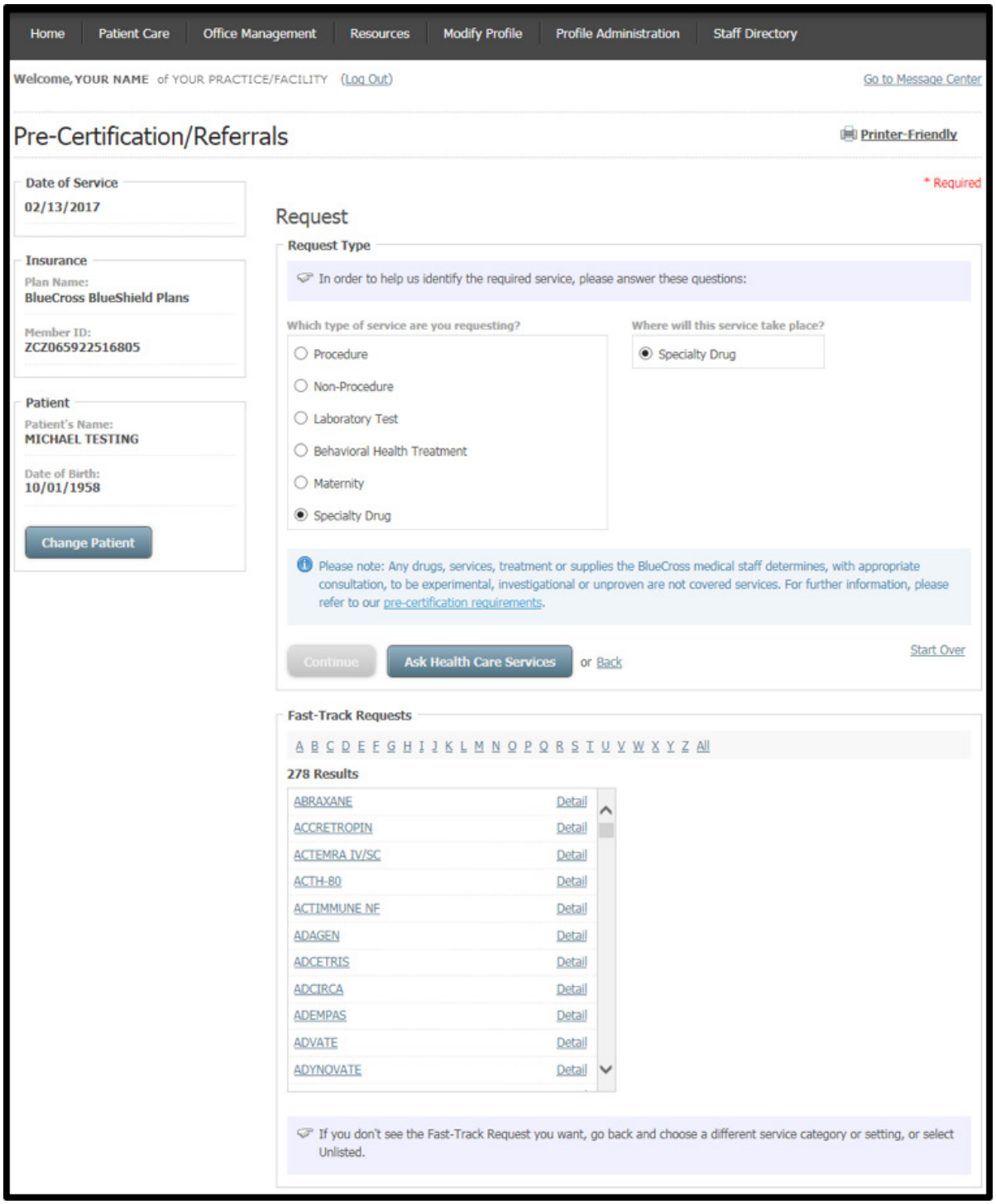
Diagnosis Information and Procedure/Service Information appear on the screen. Verify the service beginning and end dates. **Continue**. Click **Change Fast-Track Selection** if you need to return to the previous screen.



At the Other Information screen, provide additional information for level of service [E-Elective; 03-Emergency; U-Urgent]; Release of information; Facility providing service; Provider(s); and the Practice.

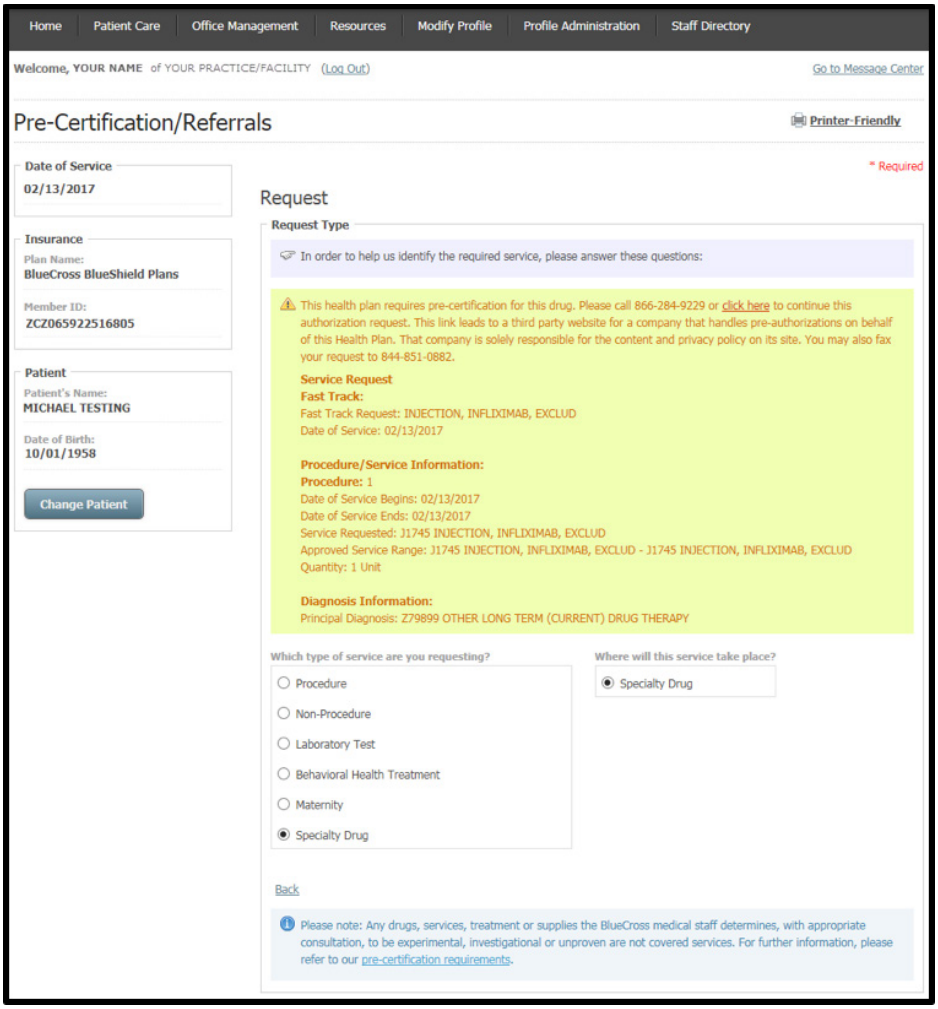
Continue. Follow the process through Verification and Authorization Confirmation screens.

Pre-Certification/Referral – Specialty Medical Drugs Instruction



From the Patient Care tab, select Pre-Certification/Referrals. Enter all required patient and location information. At the Request Type screen, choose Specialty Drug as the service type and Specialty Drug as where the service will take place. **Continue**.

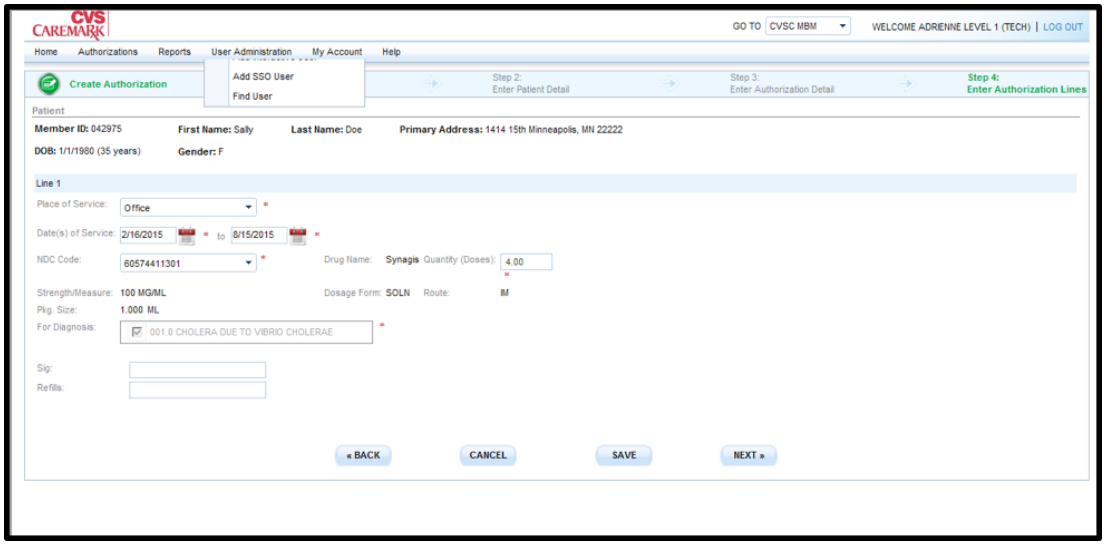
You will see the Fast-Track Requests field after you select the location. Place the cursor on the desired procedure to select.



A message appears alerting you of special pre-certification/referral requirements for the selected service. Certain specialty drugs require pre-certification via the CVS/caremark* online authorization tool, Novologix. Call 866-284-9229 or follow the **click here link** to continue.

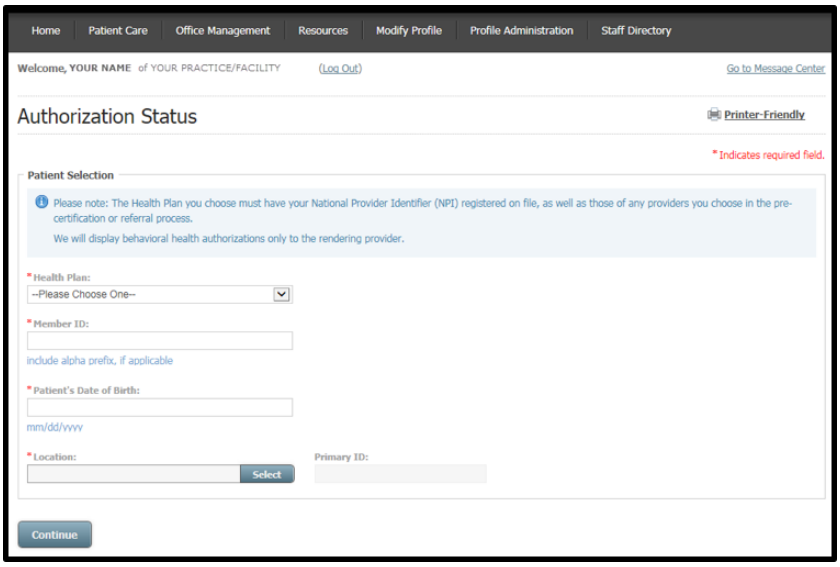
Other specialty drugs (for example, certain self-administered drugs) that do not require authorization via Novologix will continue through the My Insurance Manager pre-certification/referral process.

*CVS/caremark – a division of CVS Health – is an independent company that provides pharmacy services on behalf of BlueCross and BlueChoice.



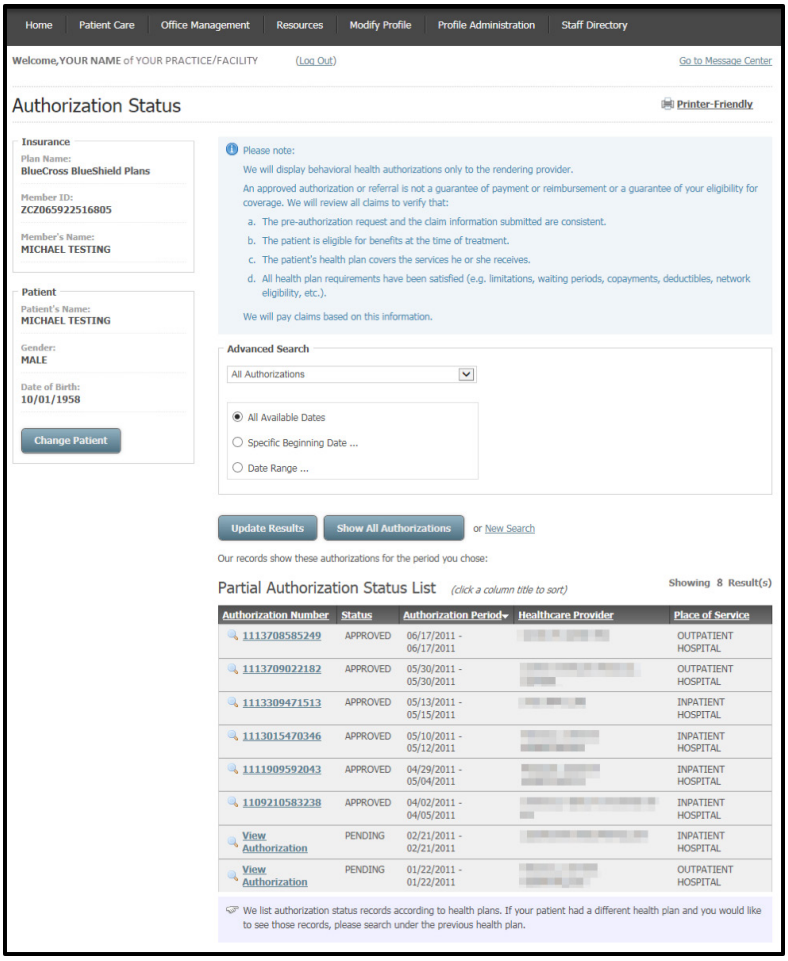
This screen appears when you follow the link to CVS/caremark's Novologix provider portal. Follow the Novologix pre-certification process through subsequent screens to complete.

Authorization Status



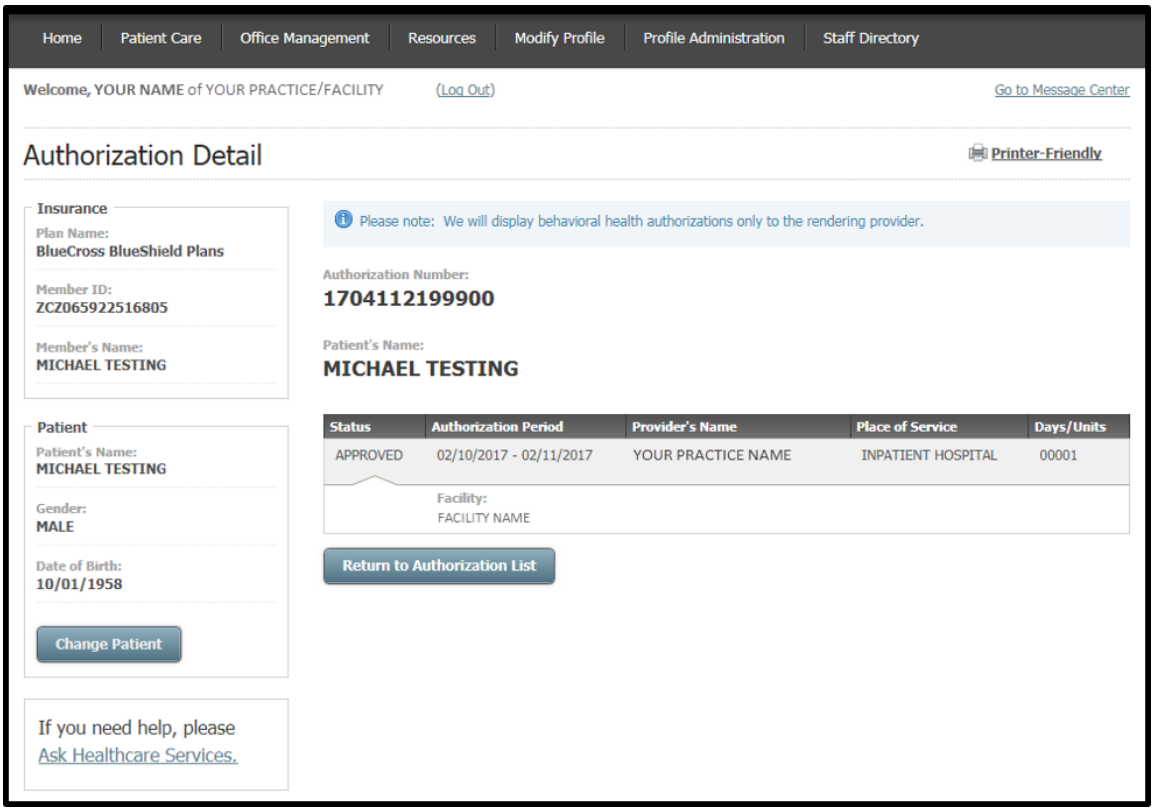
From the Patient Care menu choose Authorization Status. Complete the required information; make sure to enter the member ID exactly as it appears on the patient's insurance card, including the alpha prefix if applicable.

Continue.

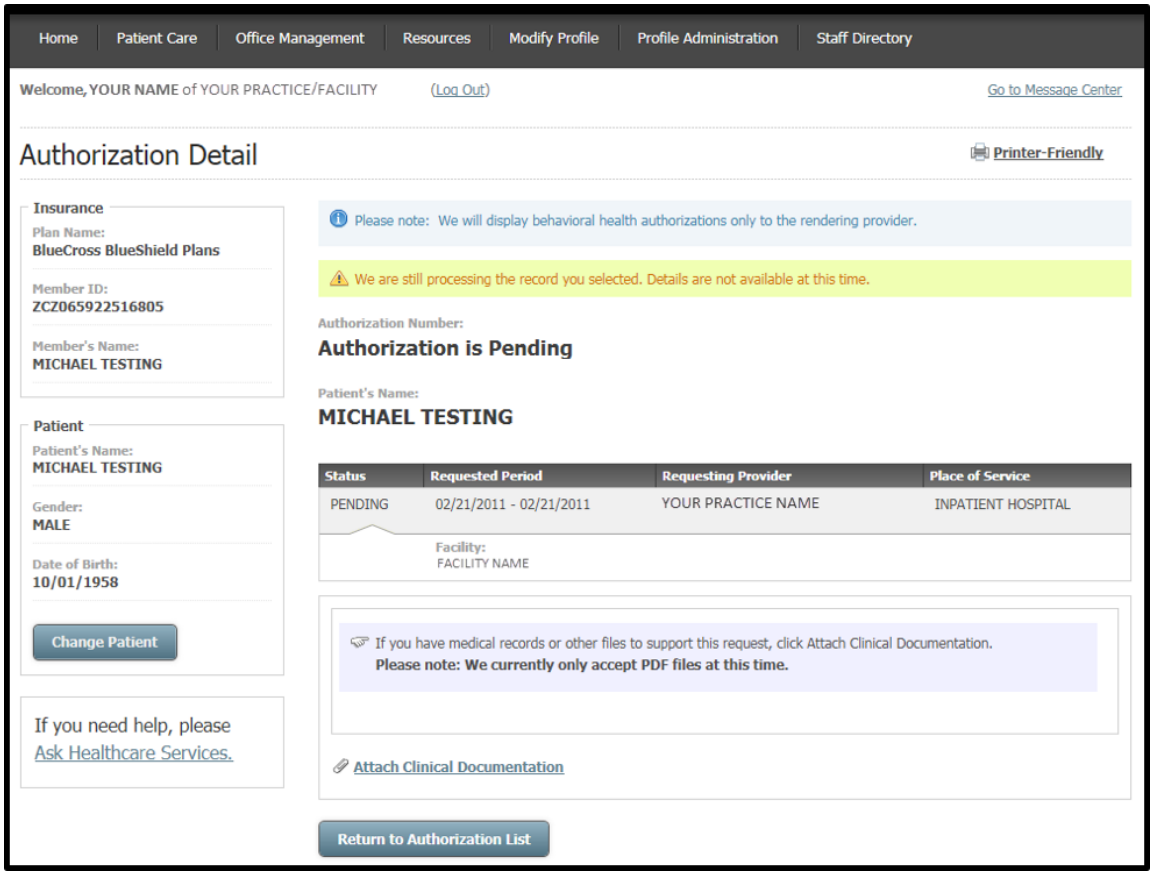


The Authorization Status screen displays next. You can narrow the Partial Authorization Status List according to search by All Available Dates, Specific Beginning Date or Date Range, then Update Results.

Follow the Authorization Number link to view an approved authorization; follow the View Authorization link to view a pending authorization.

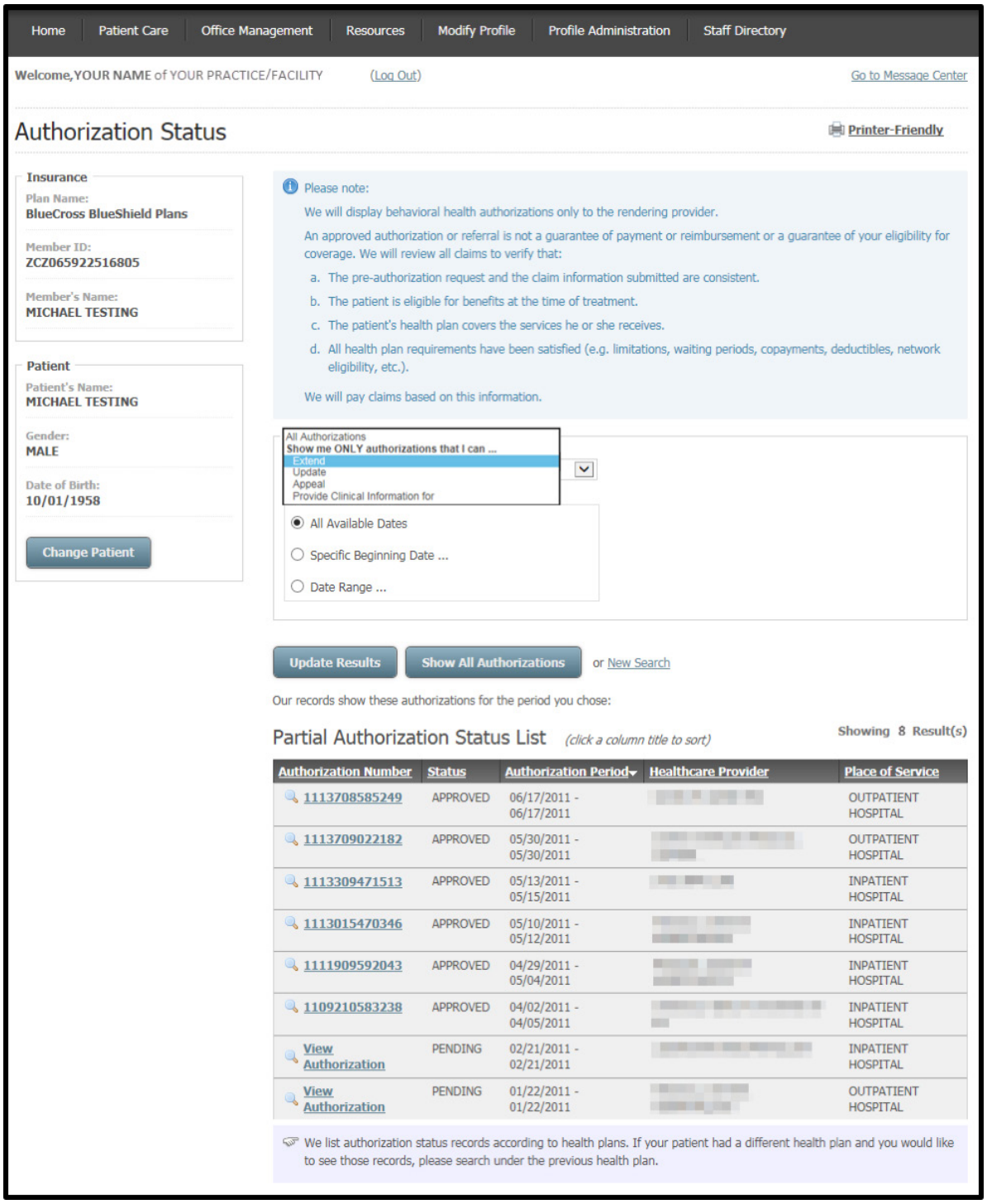


This Authorization Detail screen appears when you follow the authorization number link from the Partial Authorization Status List. Click **Return to Authorization List**, **Change Patient** or **Ask Healthcare Services** as appropriate.



This Authorization Detail screen appears when you follow the View Authorization link from the Partial Authorization Status List. Click **Attach Clinical Documentation**, **Return to Authorization List**, **Change Patient** or **Ask Healthcare Services** as appropriate.

Authorization Extension

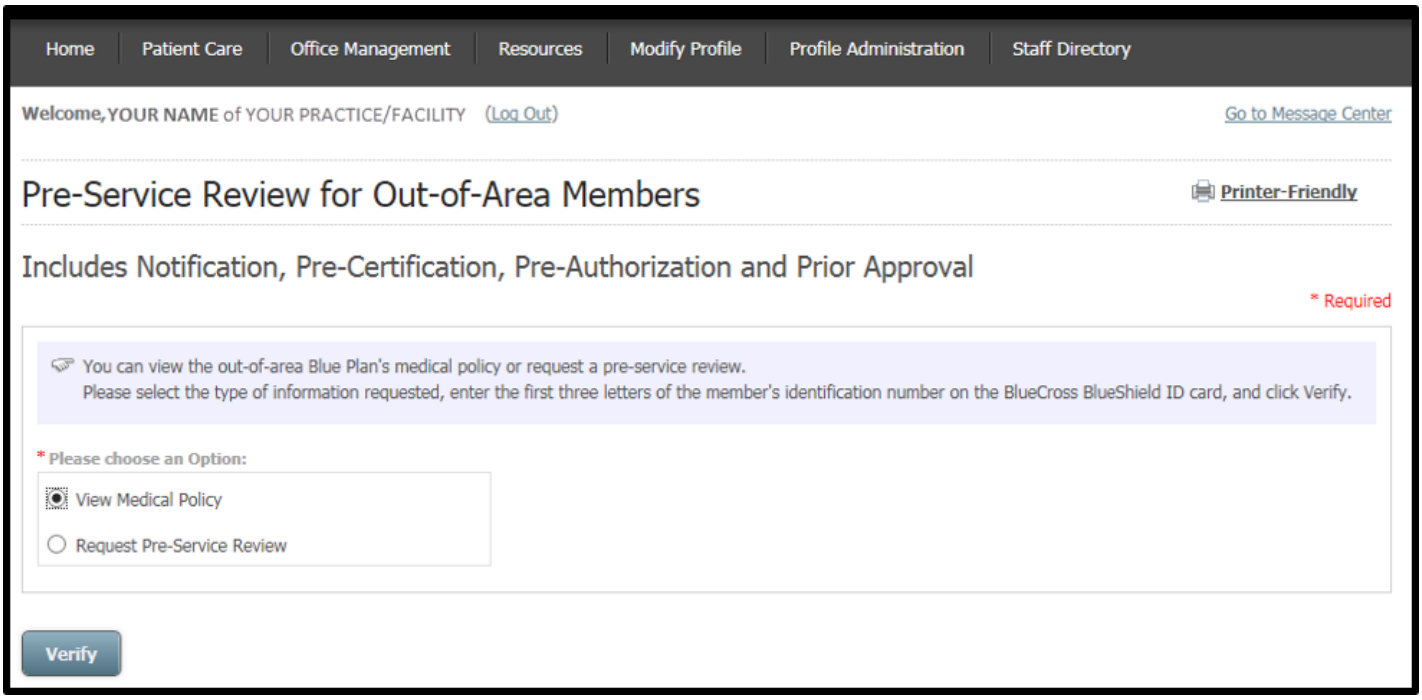


From the Patient Care menu choose Authorization Extension. Complete the required fields and Continue. The Authorization Status displays next. The Advanced Search field defaults to Extend.

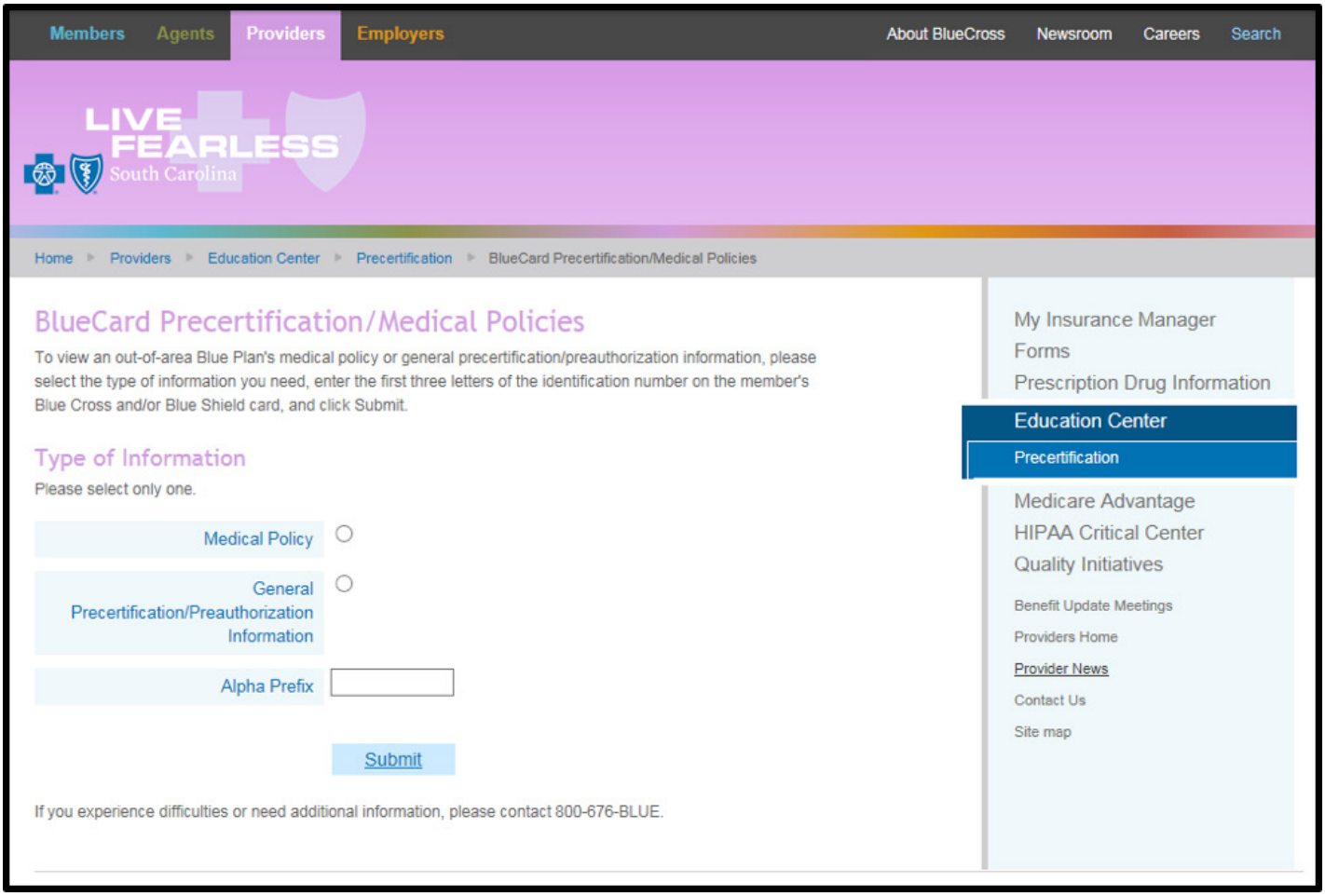
You can also select Extend [or Update; Appeal; Provide Clinical Information for] from the drop-down menu on the Authorization Status screen of a previous authorization status search.

The Partial Authorization Status List is shown. You can narrow the authorization status list according to search by All Available Dates, Specific Beginning Date or Date Range, then **Update Results**.

Pre-Service Review for Out-of-Area Members



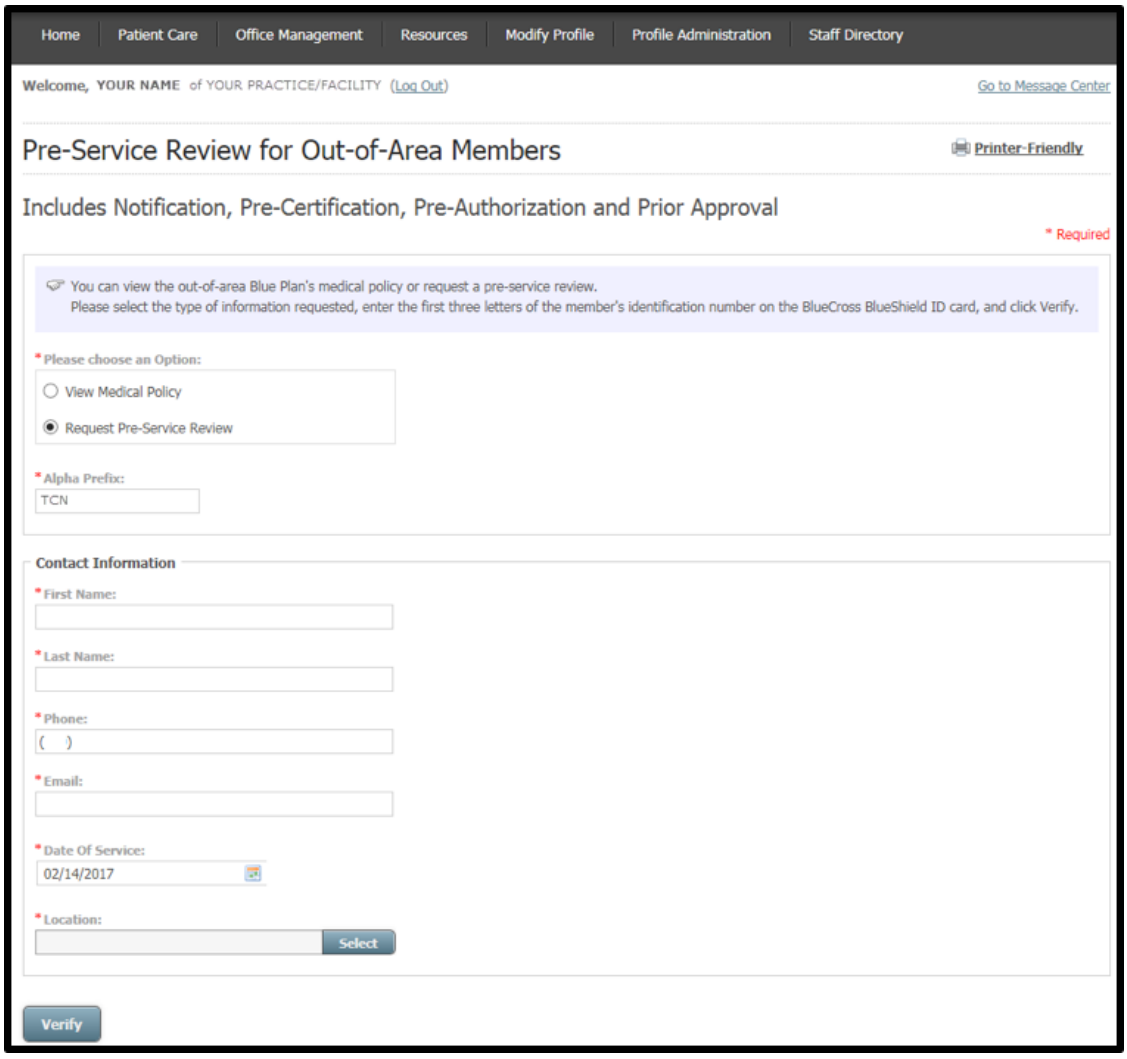
From the Patient Care menu choose Pre-Service Review for Out-of-Area Members. Select View Medical Policy or Request Pre-Service Review; then Verify.



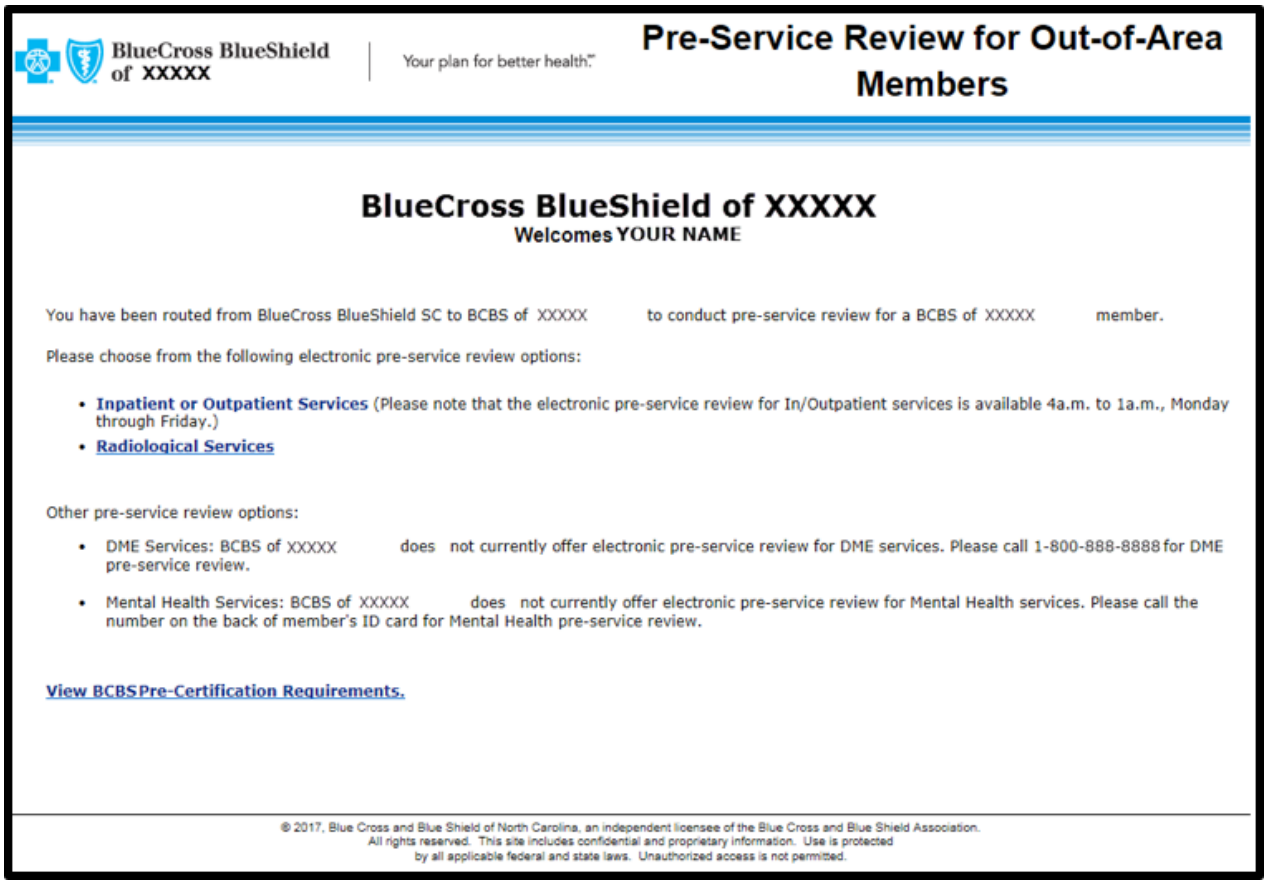
When you select View Medical Policy, you will be redirected to this page of www.SouthCarolinaBlues.com. Choose Medical Policy, enter the Alpha Prefix and **Submit**.

You will be taken to the landing page of the other Blue Plan.

When you select Request Pre-Service Review, the screen expands to show additional required fields.

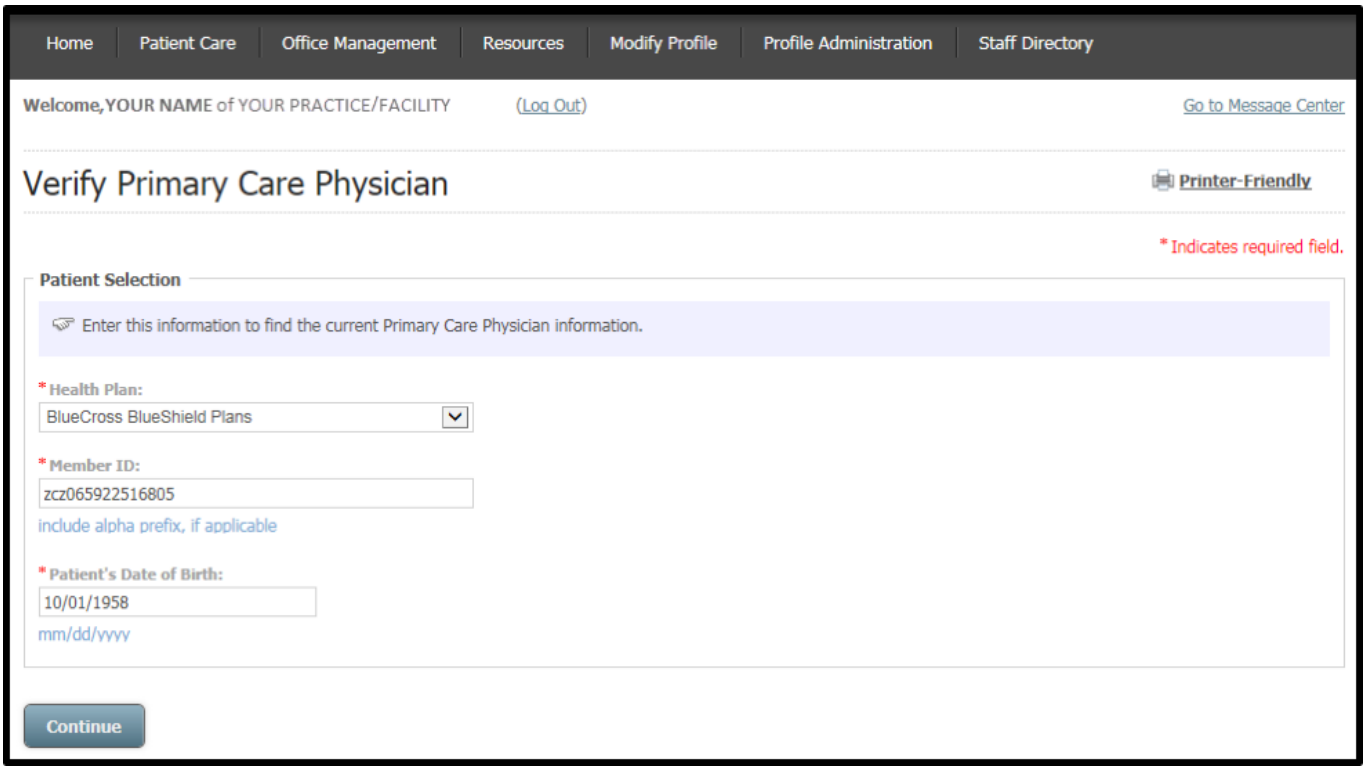


Complete all entries and **Verify**.



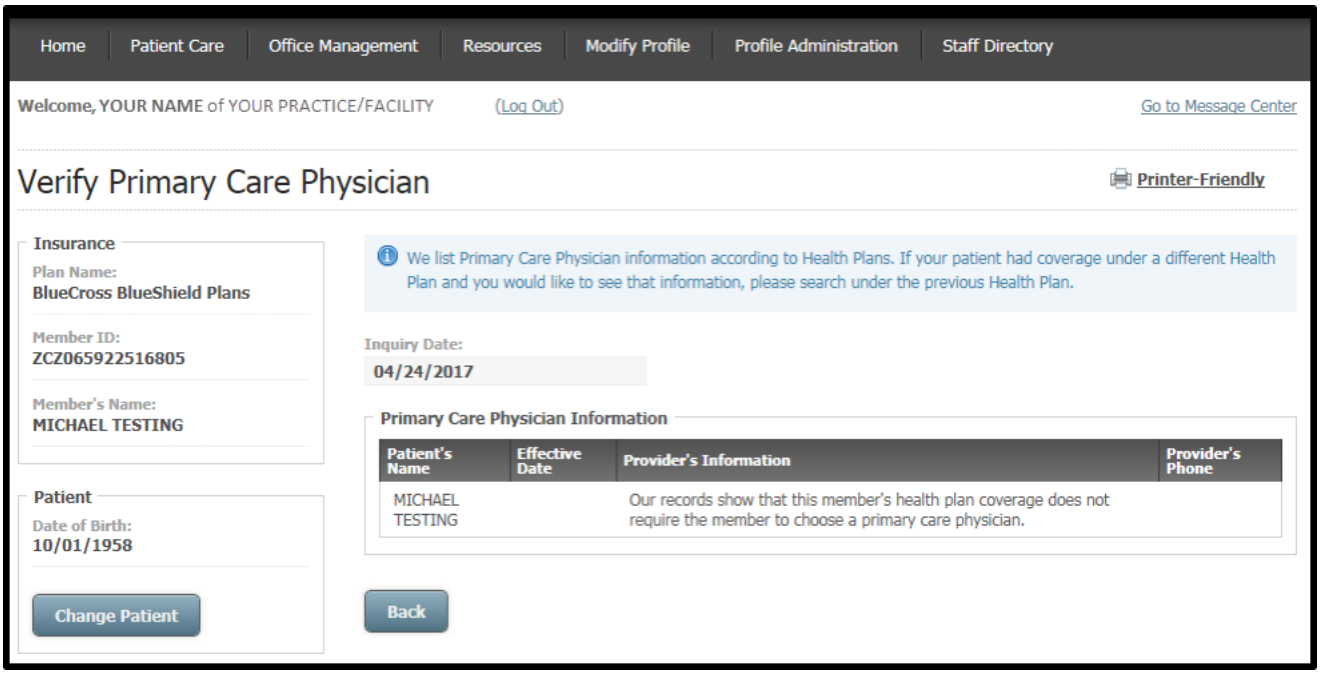
You will then be taken to the pre-certification page of the other Blue Plan.

Verify Primary Care Physician

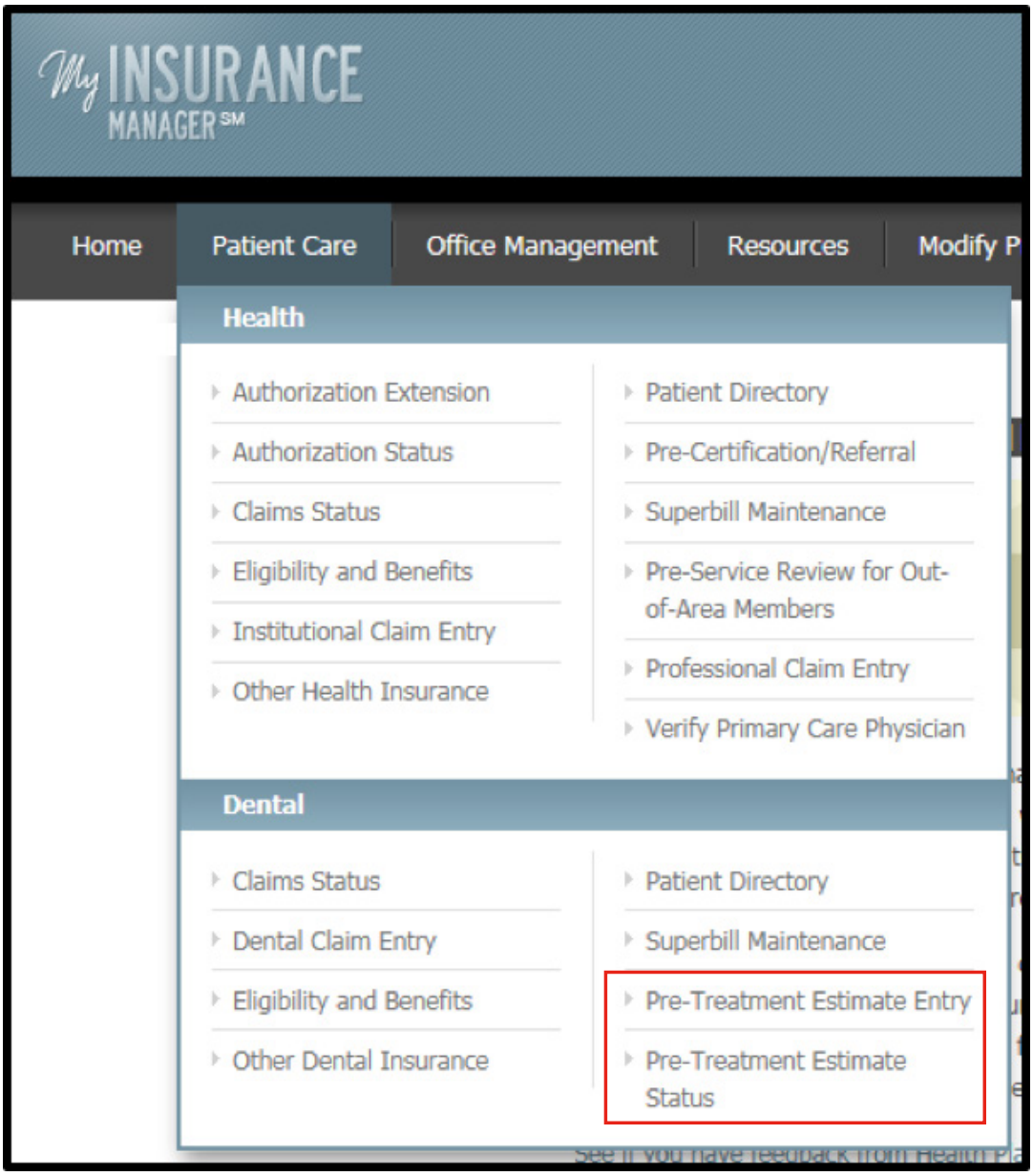


From the Patient Care menu choose Verify Primary Care Physician. Complete the required information; make sure to enter the member ID exactly as it appears on the patient's insurance card, including the alpha prefix if applicable.

Continue.

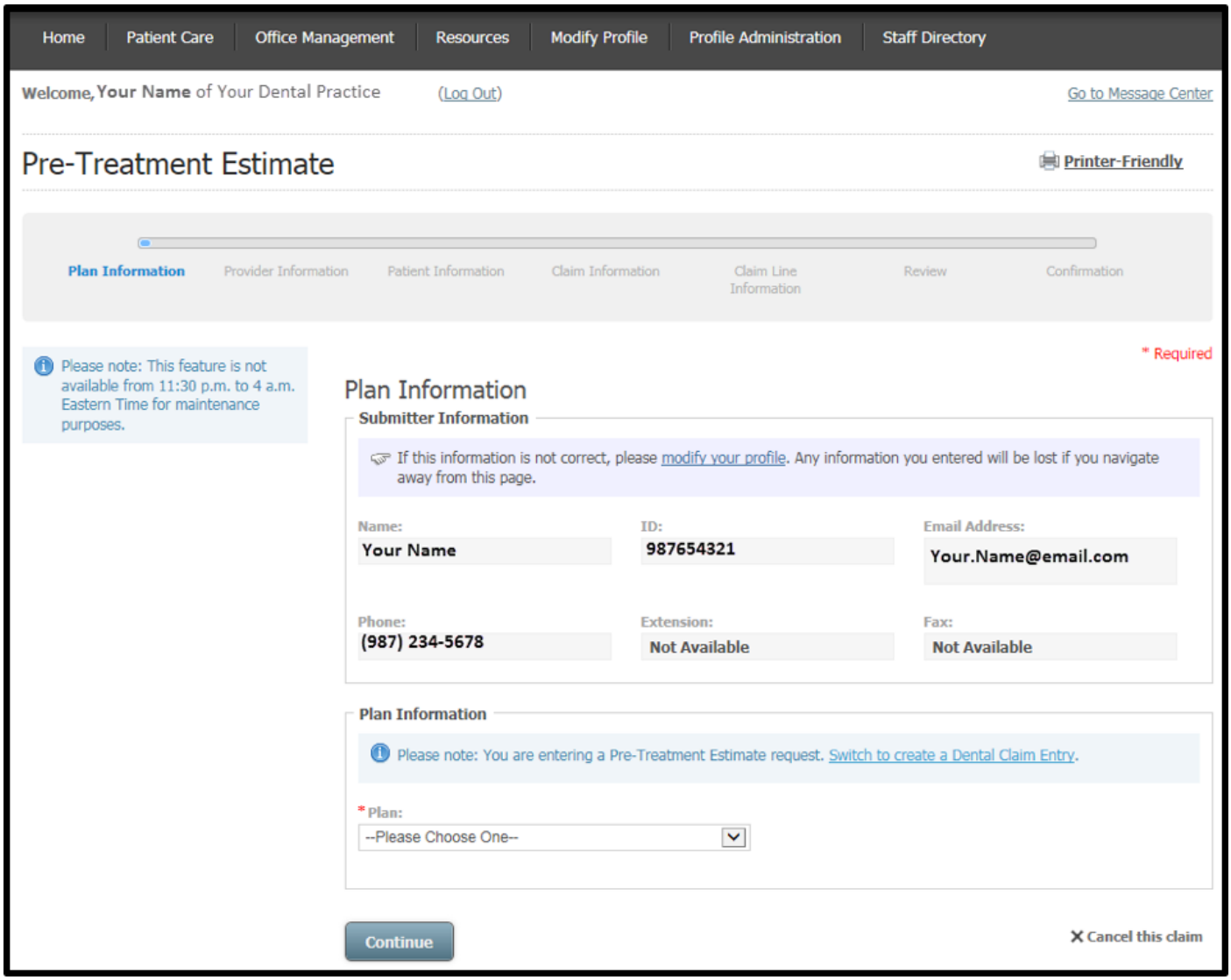


The Primary Care Physician Information will display on the next screen if applicable to the member's health plan.

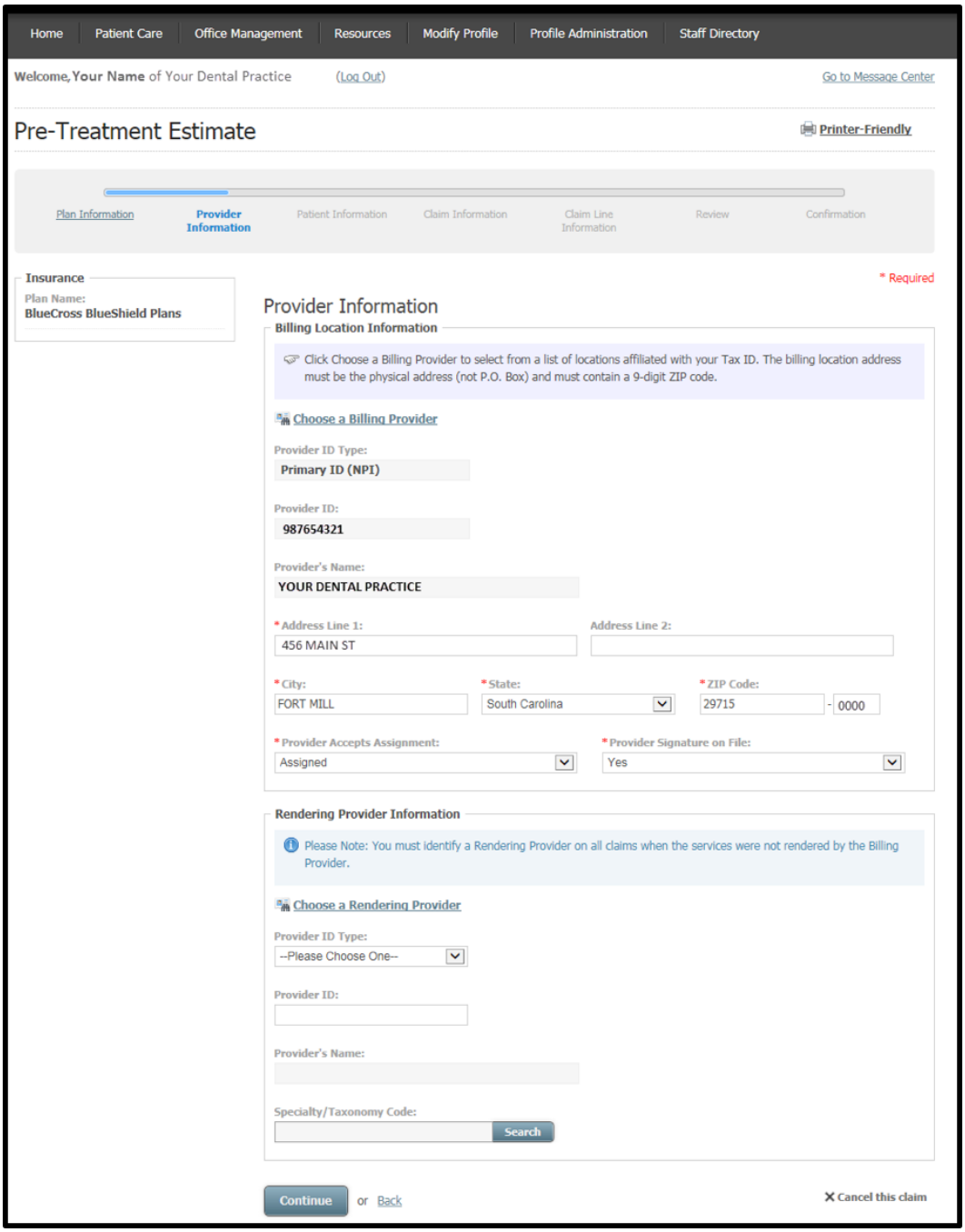


From the Patient Care menu, choose Pre-Treatment Estimate Entry to get a real-time snapshot of the benefits that are payable at the time the pre-treatment processes. This is considered a prior authorization. Select Pre-Treatment Estimate Status to see if we have approved the prior authorization request or if it is pending for additional information.

Pre-Treatment Estimate Entry



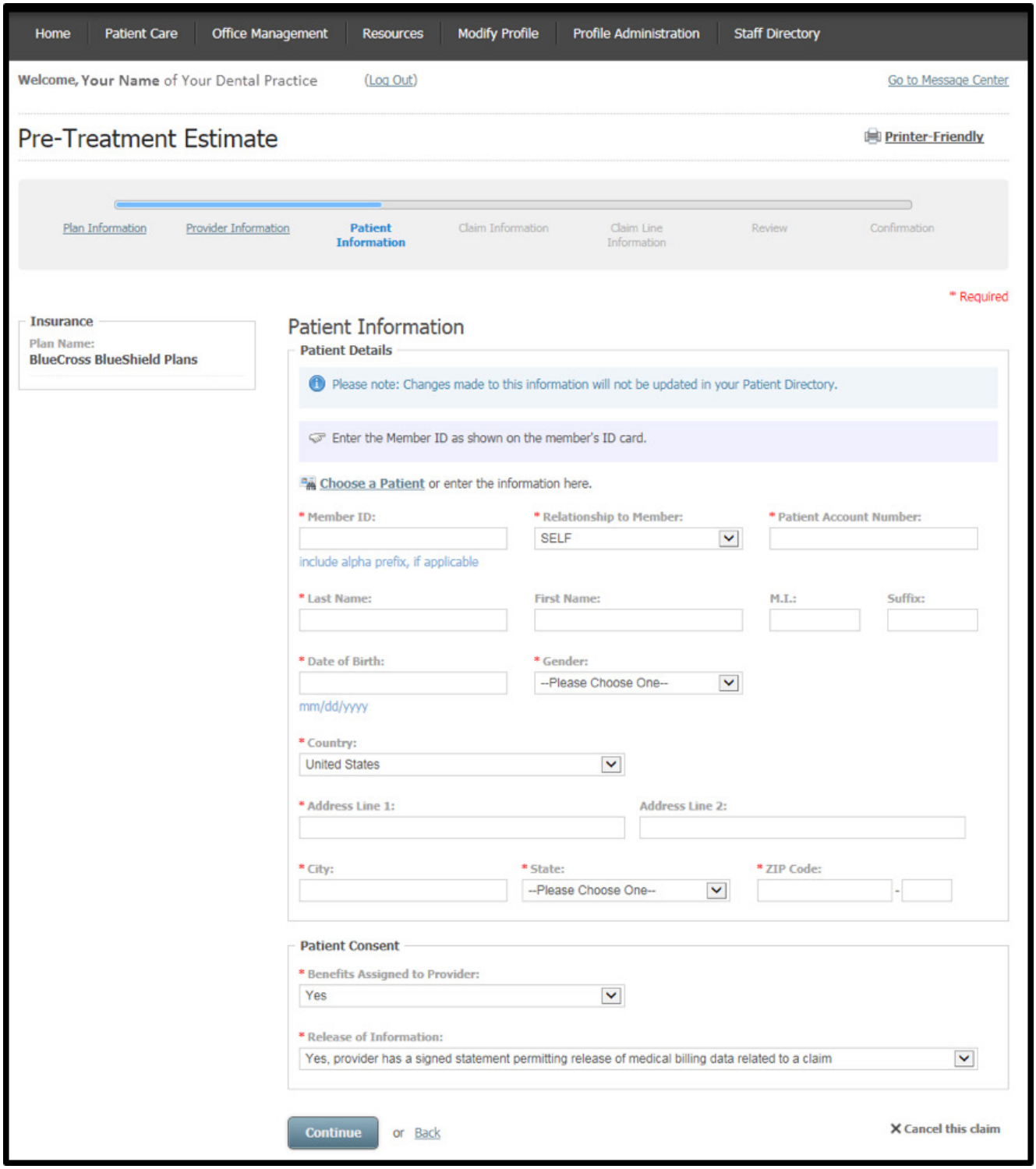
From the Patient Care menu choose Pre-Treatment Estimate Entry. The Plan Information screen gives information about the submitter (i.e., the user account information). Select a plan and **Continue**.



From the Provider Information screen click the hyperlinks for **Choose a Billing Provider** and/or **Choose a Rendering Provider** to have this information auto-populated.

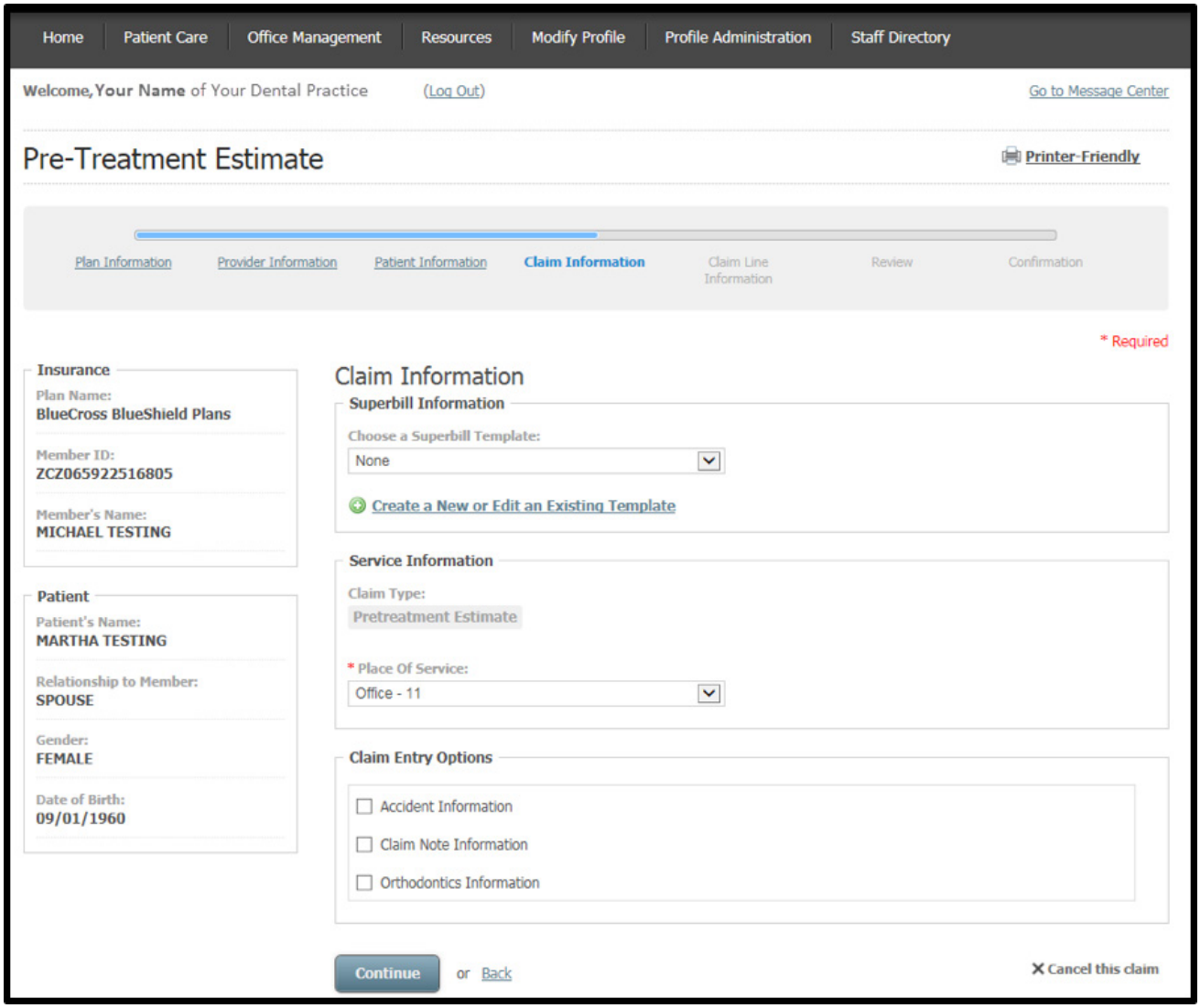
Choose a rendering provider if it differs from the billing provider.

A Specialty/Taxonomy Code is required when you enter the rendering provider information. Use the National Plan & Provider Enumeration System's (NPPES) website to locate your rendering provider's specialty/taxonomy code if you are unfamiliar with this number. NPPES is a separate program ran by the Centers for Medicare & Medicaid Services that handles these unique identifiers. Users can also find the specialty/taxonomy code in My Insurance Manager by searching for a partial code or description. **Continue**.



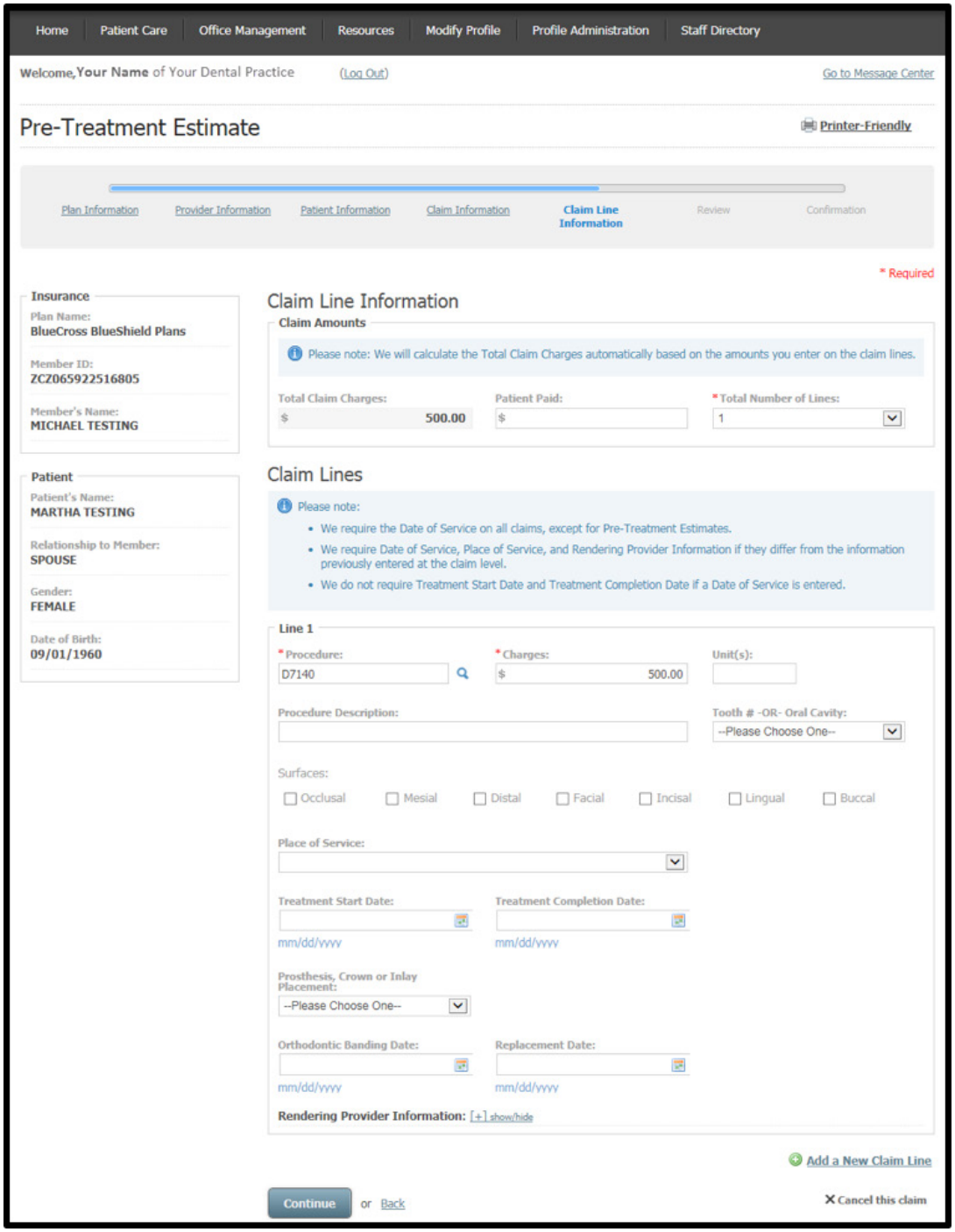
On the Patient Information screen, add the required patient data elements as a one-time entry or use the Patient Directory.

At the Patient Account Number field input the patient's unique number your practice or practice management software has assigned. You can create a patient account number if one does not exist. **Continue**.



The next pre-treatment estimate entry screen is Claim Information. Bypass the option to choose or create/update a superbill from the drop-down menu. Choose the place of service. If appropriate, add Claim Entry Options by checking the box that corresponds with the claim information to be included.

Continue.



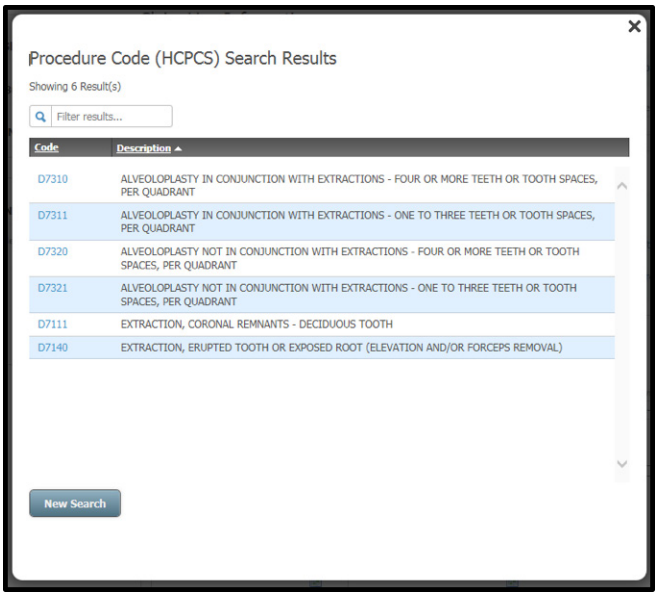
Claim Line Information is the fifth screen in the pre-treatment estimate entry process. Enter the total number of lines (up to 50 lines) in the Claim Amounts section. There is also a second chance to include additional claim lines by clicking the **Add a New Claim Line** link at the bottom of the screen. Claim amounts will automatically calculate based on the amounts you enter on the claim lines.

In the Claim Lines section, enter the procedure code and charges in those required fields. Search for the specific procedure code by clicking the magnifying glass icon.

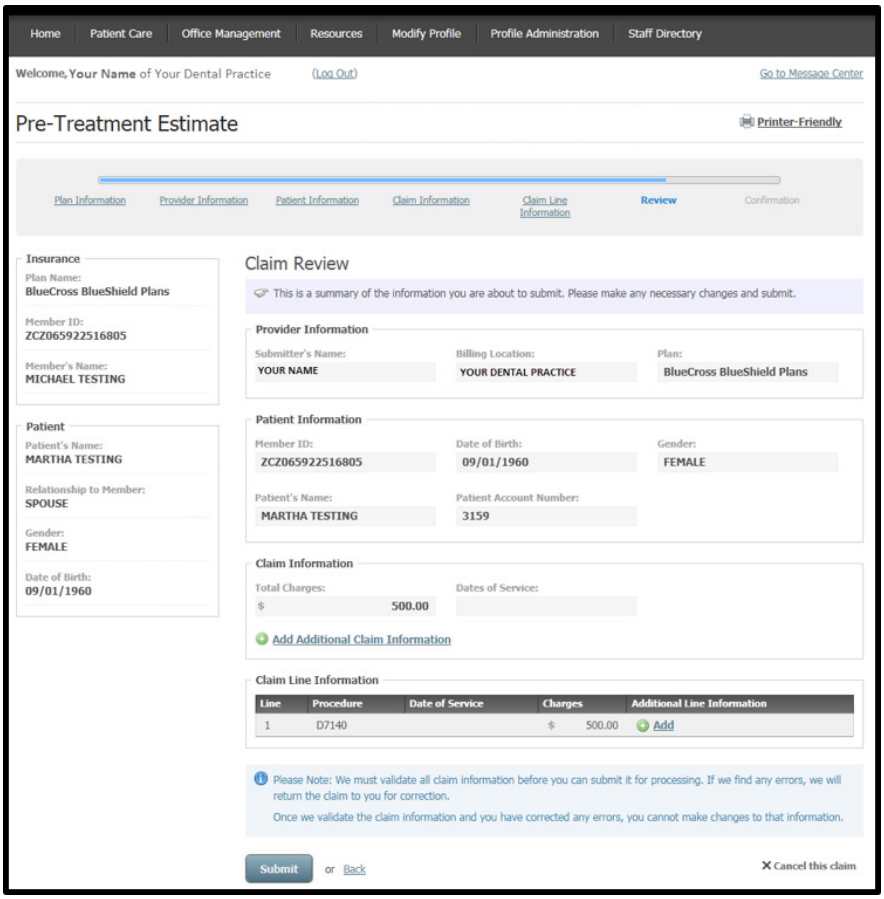
Choose the tooth number or oral cavity from the drop-down menu. Selecting a tooth number or oral cavity is optional.

Enter additional information as appropriate for Treatment Start/Completion Dates; Prosthesis, Crown or Inlay Placement; Orthodontic Banding/Replacement Dates; and Rendering Provider Information.

Continue.



This screen appears when searching for a procedure code. Search by description or code. Place your cursor on the desired procedure code to select it and be returned to the prior screen.



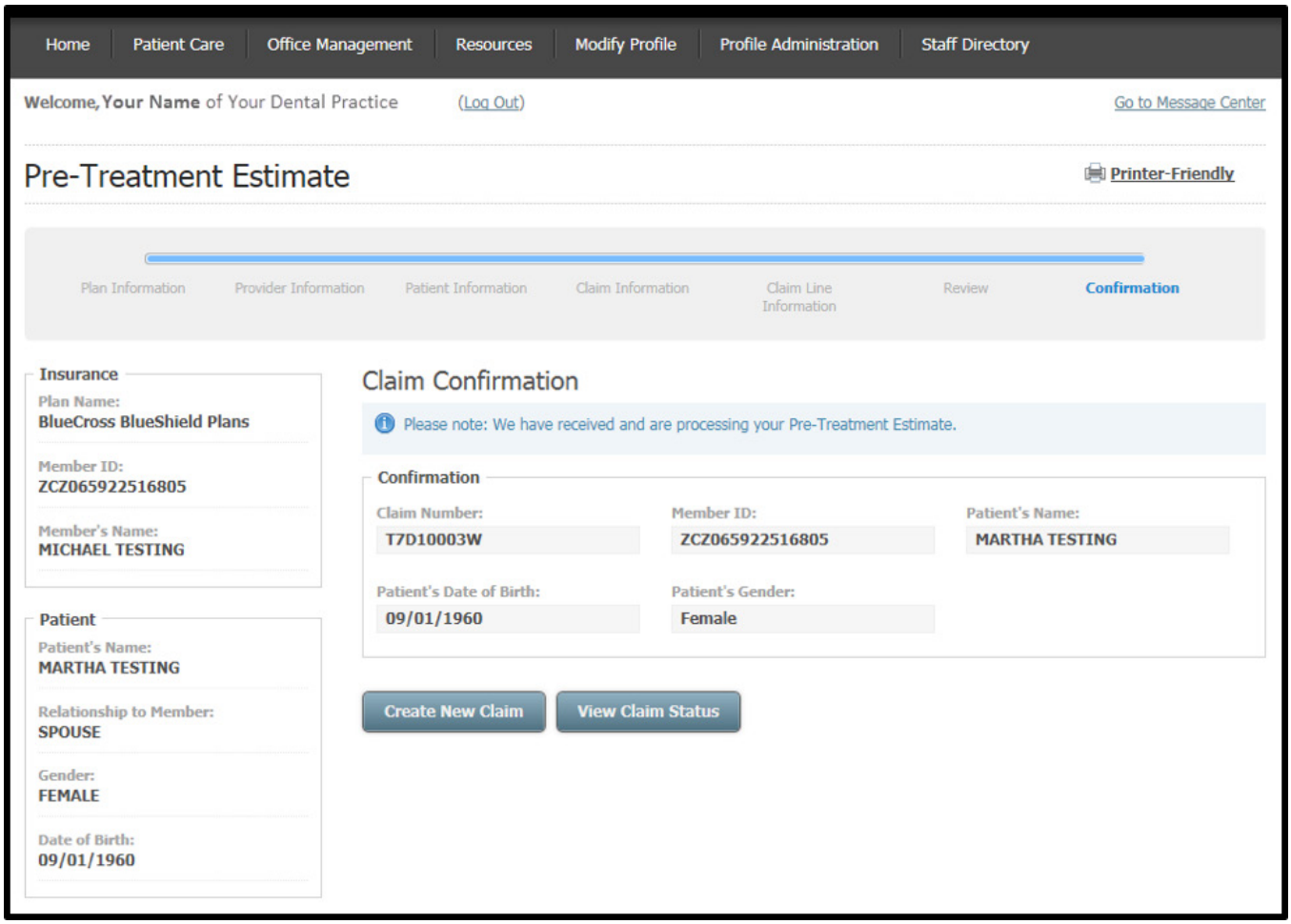
From the Review screen, examine your entries for the pre-treatment estimate. Submit the pre-treatment estimate or return to any previous screen using the **back** hyperlink or clicking on a screen title on the progress bar.

Select **Add Additional Claim Information** to add claim-level information.

To add information that applies to an individual claim line, click the **Add** link on the line to which the information applies.

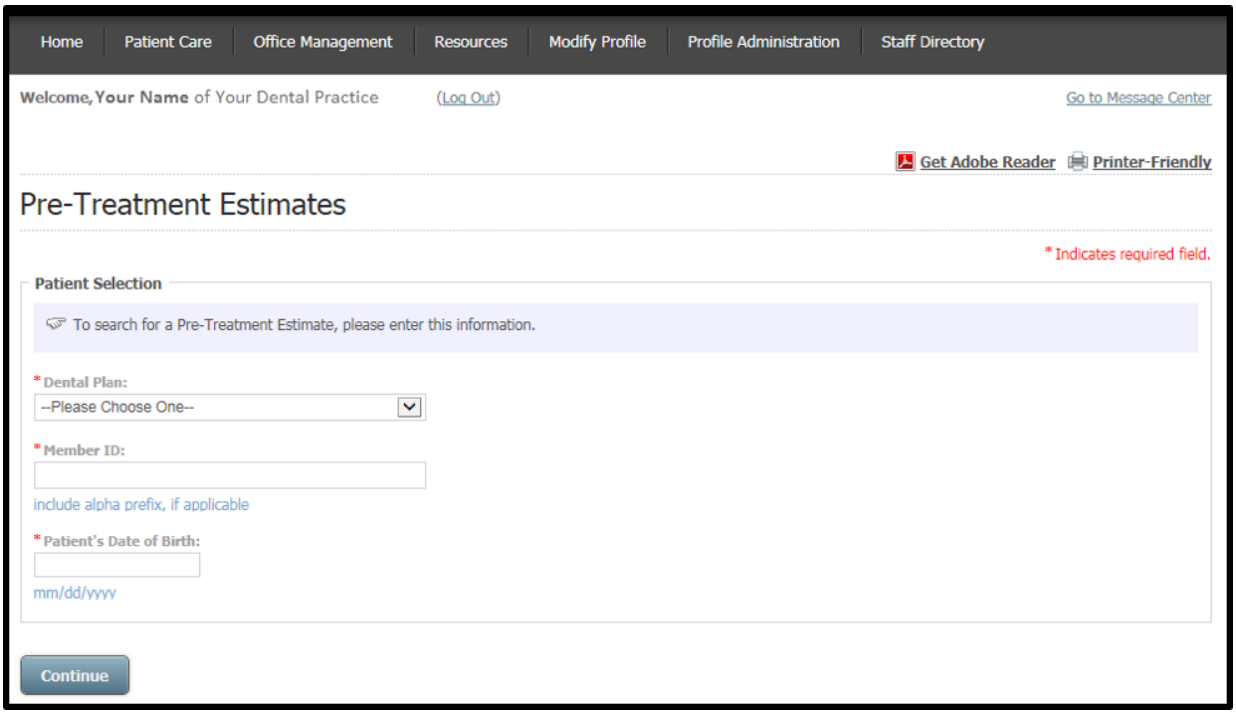
There is an option to **Cancel the claim** found at the bottom of each screen of the claim entry process.

Submit.

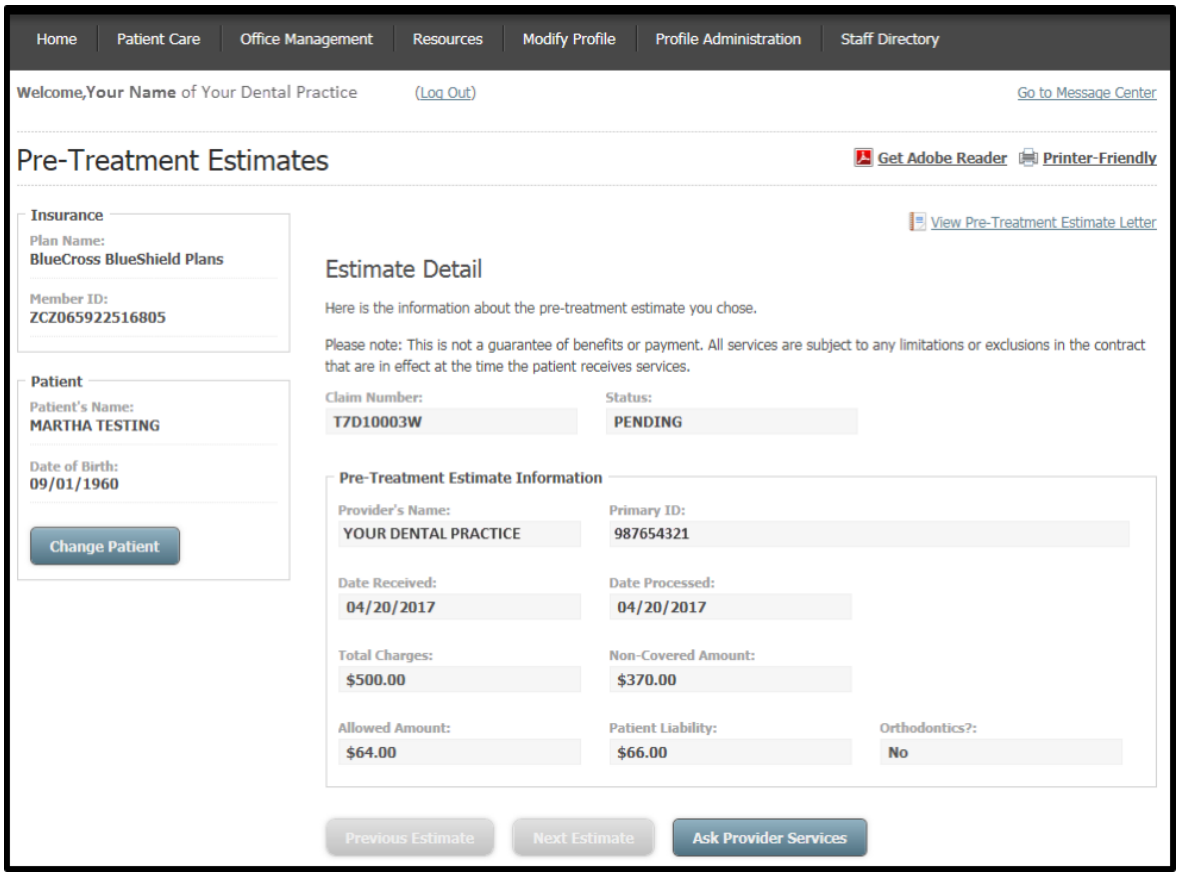


A claim number displays on the Claim Confirmation screen. You can now begin a new pre-treatment estimate or view the status of a pre-treatment estimate.

Pre-Treatment Estimate Status



From the Patient Care menu choose Pre-Treatment Estimate Status. Select a dental plan, and enter the member ID and patient's date of birth. **Continue**.



The Estimate Detail screen displays next. Look to the Status field to determine if the estimate is in a pending or approved status.

You can now choose to send a secure email to Provider Services by clicking **Ask Provider Services**; or view **Previous Estimate** or view **Next Estimate**.

Troubleshooting Tips – Patient Care Functions

- If you get a “not covered” response with an eligibility end date of 12/31/999, this means a member’s dependent has been termed on an active policy. If you get a “covered” response with an eligibility end date of 12/31/9999, this means the patient (subscriber or dependent) is active.
- You cannot view dental eligibility and benefits for FEP BlueDental or out-of-state members.
- The dental code entered on the Eligibility and Benefits by Procedure Code inquiry may not be the procedure code returned on the eligibility response. The procedure code on the eligibility response is the code we will use to process the claim for this service. For example, when D2740 is entered the eligibility response will display details for D2751. An explanation for the code substitution is given.
- If you’ve reviewed your claim entry and continue to get an error message that states missing information is required, be sure an additional claim line field has not been expanded. For example, if you clicked the show/hide link for Drug Identification when you entered Claim Line Information but did not have prescription drug information to add, the claim will not submit without this information or without collapsing this option.
- B06 Invalid Point of Origin I84
- E07 Invalid Admission Date B04
- B9A Patient Reason for Visit/Admitting Diagnosis I
- B20 Revenue Code -------Invalid I12
- H98 Room Days and/or Charges Required on Inpt
- L25 Enter a valid tooth number or oral cavity

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