

# AUTHORIZATIONS



South Carolina

*BlueCross BlueShield of South Carolina  
is an independent licensee of the  
Blue Cross Blue Shield Association.*

# 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.

# AGENDA

- Overview of Authorizations
- Process of Authorizations
- Authorization Vendors
- Resources



# **AUTHORIZATIONS OVERVIEW**



# WHAT YOU NEED TO KNOW ABOUT AUTHORIZATIONS

Authorizations are used to determine whether a service is medically necessary.

Authorization requirements can vary per plan and network.

Authorizations do not guarantee payment.

# COMMON SERVICES THAT REQUIRE AUTHORIZATION

Elective inpatient services (including maternity)

Skilled nursing facility admission

Home health and hospice

Durable medical equipment (DME)\*

Mental health and substance abuse

High tech imaging\*\*

Certain medications under the medical benefit

\* DME dollar thresholds vary per plan but are typically \$500 or \$1,000. The threshold amounts can be lower than \$500

\*\* These services are typically handled by Evolent.

# GENERAL GUIDELINES FOR AUTHORIZATIONS

Submit elective requests prior to rendering services.

Mark requests as urgent **only** when they are urgent.

Submit a notification of emergency admission within 24-48 hours of admission.

Members must have active coverage at the time of request.

Submit requests once.

Services must be covered under the member's plan.



## MAIN STEPS IN THE AUTHORIZATION PROCESS

Verify the member's benefits  
and provider network.

If authorization is required,  
initiate the request.

Receive a decision  
(Approval or denial).



# REQUIRED INFORMATION FOR AUTHORIZATIONS

## Patient Details

- Name
- ID number
- Date of birth

## Service Details

- CPT or HCPCS codes
- Diagnosis codes
- Date of service

## Location Details

- Facility
  - Name
  - Address
  - Tax ID or NPI
- Rendering
  - Name
  - Address
  - Tax ID or NPI

## Contact Information

- Phone number
- Fax number
- Email

## Clinicals

- Length of issue
- Attempted treatment
- Conservative medications
- Studies (i.e., labs, imaging)



# **PROCESS FOR AUTHORIZATIONS**



# NEW PROCESS COMING SOON

- Coming soon, we will implement a new process for requesting an authorization.
- My Insurance Manager will route you to a new web-based application, powered by Cohere Health, to enhance the efficiency of prior authorization decisions.
- Benefits of the new process include:
  - Accelerates and expands real-time approvals.
  - More seamless provider experience.
  - Decreases administrative efforts.
- The authorizations process for our third-party vendors will remain the same. This includes:
  - HealthHelp
  - Evolent
  - Avalon Healthcare Solutions
  - MBMNow
- **All clinical decisions are made by BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan.**

# HOW TO GET AN AUTHORIZATION

- There is a single sign-on through My Insurance Manager<sup>SM</sup>.
- Under *Patient Care*, select *Pre-certification/Referral*.

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

# HOW TO GET AN AUTHORIZATION (CONTINUED)

- When you reach the landing page of the new platform, you will see a full listing of authorizations under your tax identification number (TIN).
- The authorizations can be filtered by:
  - All
  - Upcoming
  - Pending review
  - Approved
  - Denied
  - Draft
  - Withdrawn
  - Completed
- You can also search for a specific patient or authorization.
- To start a new request, select ***Start auth request***.

The screenshot displays the authorization management interface for BCBS South Carolina. The page header includes the BCBS South Carolina logo, the text "powered by Cohere Health", and links for "Support" and "My account". A search bar is located at the top right, and a "Start auth request" button is highlighted with a red circle. The main content area shows a list of authorizations for a patient named John Doe. The interface includes a filter by user dropdown, a search bar, and a status filter on the left. The main content area displays a table of authorizations with columns for patient name, DOB, Member ID, Health plan, Services, Procedure codes, Submission date, and Dates of service. Each row includes a status indicator (Approved or Draft) and a "Start continuation" or "Delete" button.

Patient Name	DOB	Member ID	Health Plan	Services	Procedure Codes	Submission Date	Dates of Service	Status	Action
Doe, John	01/26/1965	10119152022	BCBS South Carolina	Physical Therapy, Speech Therapy	97110, 97112, 92507	05/15/2024 3:45 PM	06/15/2024 – 09/30/2024	Approved	Start continuation
Doe, John	01/26/1965	10119152022	BCBS South Carolina	Myocardial Perfusion Imaging Single Photon Emission Computed Tomography (MPI-SPECT),...	78451, 78452, 93015	05/15/2024 3:45 PM	06/15/2024 – 09/30/2024	Approved	Start continuation
Doe, John	01/26/1965	10119152022	BCBS South Carolina	Physical Therapy	97110	--	12/01/2022 – 03/01/2023	Draft	Delete Continue
Doe, Jane	01/26/1965	10119152022	BCBS South Carolina	Physical Therapy	97110, 97112, 97114	12/01/2022	12/01/2022 – 04/01/2023		

# HOW TO GET AN AUTHORIZATION (CONTINUED)

- Select whether the service is outpatient or inpatient.
- Include the diagnosis and procedure code(s).
- Select *Continue*.

Doe, John  
DOB: 09/16/1986

South Carolina | powered by Cohere Health | Support | My account

Tell us about your request

**Request details**

Outpatient  Inpatient

Start date  
06/01/2024

**Diagnosis codes**

Primary diagnosis code  
M48.06

Search for secondary diagnosis codes (optional)

**Procedure codes**

CPT/HCPCS codes  
63047 x

Save and exit | Cancel | Continue

*Note: You have the option to save and exit the request at any time. You can also cancel the request if it's no longer needed.*

# HOW TO GET AN AUTHORIZATION (CONTINUED)

- Enter the provider details to include:
  - Ordering provider.
  - Performing or attending provider.
  - Performing facility or agency.
- There is a TIN search feature to make the process easier.
- Select ***Continue***.

The screenshot shows a web form titled "Providers" with the following sections:

- Care setting:** Radio buttons for "Outpatient" (selected) and "Inpatient".
- Place of service:** A dropdown menu.
- Ordering provider:** A search box with the placeholder "Search for an ordering provider by NPI, TIN, or name" and a magnifying glass icon. To the right are buttons for "TIN" and "Address", each with a magnifying glass icon. A blue pill-shaped button below the search box contains "+ Bailey, Christopher Eric MD".
- Performing or attending provider:** A checkbox labeled "Performing is the same as the ordering" (unchecked). Below it is a search box with the placeholder "Search for a performing or attending provider by NPI, TIN, or name" and a magnifying glass icon. To the right are buttons for "TIN" and "Address", each with a magnifying glass icon. A blue pill-shaped button below the search box contains "+ Bailey, Christopher Eric MD".
- Performing facility or agency:** A search box with the placeholder "Search for a performing facility or agency by NPI, TIN, or name" and a magnifying glass icon. To the right are buttons for "TIN" and "Address", each with a magnifying glass icon. A blue pill-shaped button below the search box contains "+ 1ST START HEALTHCARE SERVICES".

At the bottom left of the form, there is a link that says "Save and exit".

# HOW TO GET AN AUTHORIZATION (CONTINUED)

- On this screen, the top portion will tell you which codes you requested require authorization.
- The bottom portion will tell you which codes do not require authorization.
- There's an option to expedite the request if it's an ***urgent matter***.
- Select ***Continue***.

Requires authorization

Start date: 04/30/2024 - End date: mm/dd/yyyy

Physical Therapy (PT)

Number of visits: 1

97110 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

+ Add a procedure code

Total Knee Arthroplasty (TKA)

27447 Units: 1 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) Remove

+ Add a procedure code

Expedite

! Doesn't require authorization in most cases 93798 Download PDF

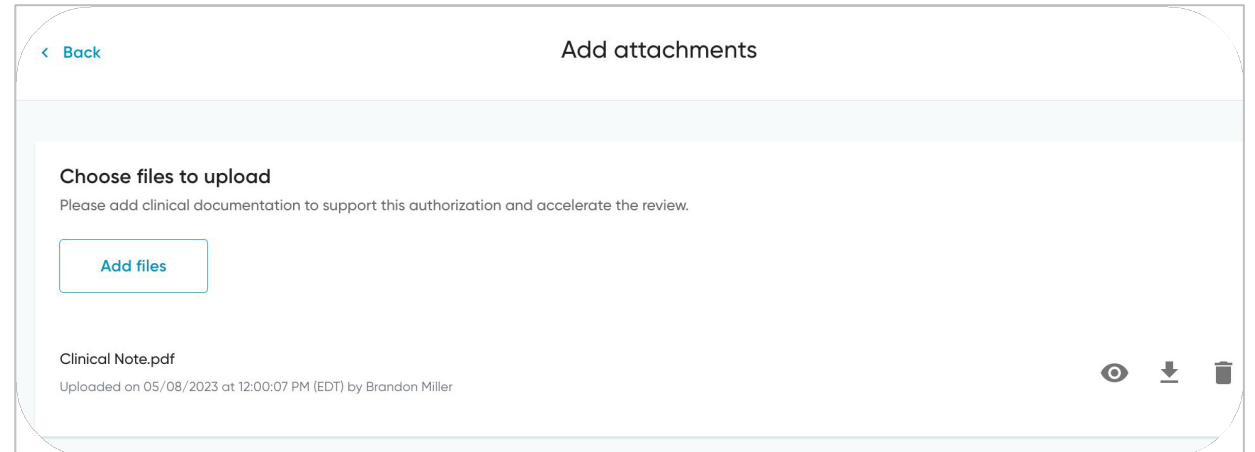
Save and exit Continue with 2 codes

Note: The continue option will indicate the number of codes being requested for review.



# HOW TO GET AN AUTHORIZATION (CONTINUED)

- Upload all relevant clinical documentation for review.
- You will have the option to review the uploaded items or remove them.
- Select ***Continue***.




# HOW TO GET AN AUTHORIZATION (CONTINUED)


- Review all the relevant information.
- Select ***Submit services***.



[Back](#) Review services before submitting

---

 Physical Therapy (PT), Total Knee Arthroplasty (TKA)


**This request duplicates an existing one**  
Duplicate submissions may be voided. The care setting (outpatient or inpatient), performing provider (if applicable), and facility match an existing request, including overlap in procedure codes and service dates.

 You can choose to withdraw the existing request, change details to avoid duplication, or call Cohere for assistance at (833) 283-0033.

 Draft  Delete


Tracking #WKGB4665

---

**Details**  Edit

Primary diagnosis	M25.561 - Pain in right knee
Secondary diagnosis	--
Care setting	Outpatient
Place of service	Ambulatory Surgical Center

[Save and exit](#) Submit services



**1 evidence-based suggestion to improve your request:**

**Expedited → Not expedited**  
The coverage and/or services on this request do not meet the requirements for an expedited request.

[Accept](#)



# HOW TO GET AN AUTHORIZATION (CONTINUED)

- You will be notified once the authorization is approved.
  - Portal notification
  - Faxed notification
- To view additional details, select ***View service summary*** inside the portal.

South Carolina | powered by Cohere Health

**Your request has been approved**

Tracking #: **NPOA6057**  
Dates of service: **06/01/2024 – 09/30/2024**

Hello <user's name>,

Thank you for submitting a service request with... reviewed your request and it has been approved... decision (including the authorization number) i

[View service summary](#)

South Carolina | From: **Cohere Health** | Date requested: **05/01/2024** | [Response](#)  
powered by Cohere Health

**We have finished processing your service request**  
To review the status of your request please go online to [next.coherehealth.com/check\\_status](https://next.coherehealth.com/check_status)

**Still faxing?** If so, you're missing out on timesaving benefits, including immediate auth decisions and transparent in-app clinical guidelines only available when using the CohereNext:® web portal to manage preauthorizations. Registration only takes a few minutes, and unlocks access for all users at your practice organization. Visit [www.coherehealth.com/register](https://www.coherehealth.com/register) to begin.

Final Determination: **Approved** | Auth #: **NPOA6057** | Tracking #: **NPOA6057**

Patient: **John Doe** | Patient DOB: **01/26/1965**

CPT/HCPCS code: **63047**  
Units (If applicable): **1**  
Dates of service: **06/01/2024 – 09/30/2024**



**Please note:** Physical therapy, occupational therapy, and speech therapy are not considered "urgent" services as defined in the Medicare Managed Care Manual. Therefore, Cohere Health will process all such requests according to standard timeframes.

For answers to questions regarding the Cohere systems and available resources please go online to <https://coherehealth.zendesk.com> or <https://coherehealth.com/resources>

*Note: You will also receive a notice if the request is denied.*

# HOW TO GET AN AUTHORIZATION (CONTINUED)

- The **service summary** will outline the requested authorization to include:
  - Diagnosis and procedure code(s).
  - Place of service.
  - Ordering provider.
  - Performing or attending provider.
  - Performing facility or agency.
  - Dates of service.

 South Carolina | powered by  Cohere Health Questions about this service?  
Contact BCBS South Carolina  
(000) 000-0000

---

**Service summary**  
Created on 05/01/2024

---

**Diagnosis**  
M48.06 - Spinal stenosis, lumbar region without neurogenic claudication

**Service**  
Spinal Fusion and Decompression

Code	Status	Description
63047	1 unit approved	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

---

<b>Dates of service</b> 06/01/2024 - 09/30/2024	<b>Type</b> Outpatient
<b>Member ID</b> 10119152022	<b>Ordering provider</b> Bailey, Christopher Eric MD / NPI - 1861781510
<b>Patient name</b> Doe, John	<b>Performing or attending provider</b> Bailey, Christopher Eric MD / NPI - 1861781510
<b>Patient phone number</b> (617) 283-4909	<b>Performing facility or agency</b> Peachtree Orthopaedic Surgery Center / NPI - 1902861941
<b>Patient date of birth</b> 01/26/1965	<b>Facility state</b> Georgia
	<b>Authorization number</b> BCBS South Carolina - NPOA6057

# HOW TO GET AN AUTHORIZATION (CONTINUED)

- The *patient summary* will outline the same details as the service summary but will give you the option to view the clinical documentation that was provided.

South Carolina | powered by Cohere Health | Support | My account

< Back Patient summary Start auth request

**Doe, John**  
Member ID 10119152022

Sex  
Male

DOB  
01/26/1965

Age  
59

Address  
420 Harvard St. #301 Brookline, MA

Phone  
(617) 283-4909

Preferred written language  
English

PCP grouper ID  
918401720

Plan  
BCBS South Carolina

Membership type  
Commercial

Plan type  
HMO

Plan year  
04/24/2024 - 04/24/2025

**Spinal Fusion and Decompression**

Approved  
Authorization #NPOA6057 • Tracking #NPOA6057

**Details** Edit

Primary diagnosis M48.06 - Spinal stenosis, lumbar region without neurogenic claudication

Secondary diagnosis --

Care setting Outpatient

Place of service Ambulatory Surgical Center

Ordering provider Bailey, Christopher Eric MD / NPI - 1861781510 View info

Performing or attending provider Bailey, Christopher Eric MD / NPI - 1861781510 View info

Performing facility or agency Peachtree Orthopaedic Surgery Center / NPI - 1902861941 View info

Dates of service 06/01/2024 - 09/30/2024

Expedited No

**Spinal Fusion and Decompression**

Code	Status	Description
63047	1 unit approved	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

**Attachments (1)** Edit

DoeJohn\_ClinicalNote.pdf  
Uploaded on 05/01/2024 02:39:51 PM (EST) by Connor Feick

Show clinical assessment

Requested by Connor Feick - Portal View info Withdraw



# **AUTHORIZATION VENDORS**



# THIRD-PARTY VENDORS THAT MANAGE SELECT AUTHORIZATIONS

- HealthHelp
- Evolent
- Avalon Healthcare Solutions
- Specialty Pharmacy Manager (MBMNow)
- Companion Benefit Alternatives (CBA)

*Note: These are independent organizations that offer utilization management on behalf of BlueCross and BlueChoice.*



# HEALTHHELP

- Manages authorizations for select procedures related to:
  - Musculoskeletal (MSK)
    - Procedures not currently reviewed by Evolent.
  - Cardiology
  - Surgical
  - Sleep studies
- Only applies to our Exchange plans with group numbers starting with 61, 62 and 65
- To request an authorization:
  - Use: My Insurance Manager<sup>SM</sup>
  - Call: 833-715-2255
  - Fax: 844-470-2666



# EVOLENT

- Manages the following types of authorization for most plans:
  - Radiation oncology
  - Advanced radiology
  - Musculoskeletal care (MSK)
- To request an authorization:
  - Use: My Insurance Manager or visit [www.RadMD.com](http://www.RadMD.com)
  - Call: 866-500-7664 for BlueCross members
  - Call: 888-642-9181 for BlueChoice® members



# AVALON HEALTHCARE SOLUTIONS

- Manages authorizations for lab services in the following settings:
  - Office
  - Outpatient facility
  - Independent laboratory
- To request an authorization:
  - My Insurance Manager
    - Use the Prior Authorization System (PAS)
  - Call: 844-227-5769
  - Fax: 813-751-3760
    - Fax form located on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com):
      - Providers>Policies and Authorizations>Prior Authorization>Laboratory Medical Benefits



*Note: Avalon does not review requests in an emergency room, ambulatory surgery center or inpatient hospital setting.*

# MBMNOW (SPECIALTY PHARMACY)

- Manages authorizations for certain specialty medications.
  - View the available lists on [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com).
    - Providers>Specialty and Pharmacy Drugs>Specialty Medical Medications
- To request an authorization:
  - Access MBMNow through My Insurance Manager
  - Call: 877-440-0089
  - Fax: 612-367-0742



BlueCross BlueShield of South Carolina

# COMPANION BENEFIT ALTERNATIVES

- Manages authorizations for behavioral health services.
  - Examples of services include:
    - Psychological testing
    - Behavioral health program admissions
    - Repetitive transcranial magnetic stimulation (rTMS)
- To request an authorization:
  - Visit [www.CompanionBenefitAlternatives.com](http://www.CompanionBenefitAlternatives.com).
  - Call: 800-868-1032





# **AUTHORIZATION RESOURCES**



# STANDARD PRIOR AUTHORIZATION LIST

- BlueCross developed a standard prior authorization list.
  - [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)
    - Providers>Policies and Authorizations>Prior Authorization
- The list only applies to the following lines of business:
  - National Alliance
  - Major Group
  - Small Group and Individual
  - Planned Administrators Inc.
  - State Health Plan
- **The list is not all inclusive and is subject to change. It's a guide that includes the most requested services that require medical review for prior authorizations.**



## SERVICES THAT REQUIRE PRIOR AUTHORIZATION STANDARD LIST EFFECTIVE OCTOBER 2024

Many of our plans require prior authorization for certain procedures and services. This process allows us to check ahead of time whether services meet criteria for coverage by a member's health plan. Some services on this list may not be covered by the benefit plan. **Always verify benefits prior to services being rendered.**

Prior authorization is not a guarantee of payment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied.

**This list is not all inclusive and is subject to change. It is a guide that includes the most commonly requested services requiring a medical review.** Other services may require review based on our medical policies, guidelines or the employer group's plan of benefits. **Please review specific contract verbiage for exclusions, limitations and/or maximums.**

List does not apply to medical specialty drugs. To find out which medical specialty drugs require prior authorization under the medical plan or the Specialty Medical Benefit Management (SMBM) program, refer to [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com) or My Insurance Manager™.

Some plans may require prior authorization for mental health services. Contact Companion Benefit Alternatives (CBA) to verify by calling 800-868-1032. CBA is a wholly owned subsidiary of Blue Cross Blue Shield.

### Online Resources and Tools

[www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)   [www.CompanionBenefitAlternatives.com](http://www.CompanionBenefitAlternatives.com)   <https://www.bcbs.com/blue-distinction-center/facility>

- Medical Policies
- Prior Authorization Forms and Information
- Clinical Form Resource Center
- Blue Distinction Center Facility Finder

### Prior Authorization List Applies to the Following BlueCross Lines of Business:

- National Alliance
- Major Group Fully Insured and ASO
- Small Group and Individual
- Planned Administrators Inc (PAI)
- State Health Plan

# AUTHORIZATION RESOURCES

Benefit Program	Authorization Service	Web-based Requests	Telephone Requests	Fax Requests
BlueCross	[various]	My Insurance Manager	800-334-7287	
BlueChoice	[various]	My Insurance Manager	800-950-5387	
FEP	[various]	My Insurance Manager	800-327-3238	
State Health Plan	[various]	My Insurance Manager	800-925-9724	
Avalon	Laboratory	Avalon PAS (inside My Insurance Manager)	844-227-5769	813-751-3760
CBA	Behavioral/Substance Abuse	<a href="http://www.CompanionBenefitAlternatives.com">www.CompanionBenefitAlternatives.com</a>	800-868-1032	
Evolut	<ul style="list-style-type: none"> <li>• Advanced Radiology</li> <li>• Musculoskeletal Care</li> <li>• Radiation Oncology</li> </ul>	<a href="http://www.RadMD.com">www.RadMD.com</a>	BlueCross: 866-500-7664  BlueChoice: 888-642-9181	888-656-1321
MBMNow	Specialty Medical Drug	My Insurance Manager	877-440-0089	612-367-0742



# OUT-OF-STATE MEMBER AUTHORIZATIONS

Use the BlueCard Authorization/Medical Policy tool to verify authorization requirements for out-of-state members.

Providers Providers

[Home](#) / [Providers](#) / [Policies and Authorizations](#) / [Prior Authorization](#) / [BlueCard Prior Authorization/Medical Policies](#)

## BlueCard Prior Authorization/Medical Policies

Need prior authorization for a patient who is a member of another Blue plan? If prior authorization is required, you can initiate the process through [My Insurance Manager](#)<sup>SM</sup>. Once you've logged in, go to Patient Care. Then select "Pre-Service Review for Out-of-Area Members" from the menu.

To view an out-of-area Blue Plan's medical policy or general prior authorization information, please select the type of information you need, enter the first three letters of the identification number on the member's Blue Cross and/or Blue Shield card, and click Submit.

### Type of Information

Please select only one.

Medical Policy

General Precertification/Preauthorization Information

This field is required.

Alpha Prefix

This field is required.

**Routes you to the member's Home plan.**

If you experience difficulties or need additional information, please contact 800-676-BLUE.

# OUT-OF-STATE MEMBER AUTHORIZATIONS (CONTINUED)

## Example

### BlueCard Prior Authorization/Medical Policies

Need prior authorization for a patient who is a member of another Blue plan? If prior authorization is required, you can initiate a [Manager<sup>SM</sup>](#). Once you've logged in, go to Patient Care. Then select "Pre-Service Review for Out-of-Area Members" from the

To view an out-of-area Blue Plan's medical policy or general prior authorization information, please select the type of information and enter the first three letters of the identification number on the member's Blue Cross and/or Blue Shield card, and click Submit.

#### Type of Information

Please select only one.

- Medical Policy
- General Precertification/Preauthorization Information

#### Alpha Prefix

YPP

Submit

If you experience difficulties or need additional information, please contact 800-676-BLUE.

The screenshot shows the Blue Cross NC website interface. The top navigation bar includes the Blue Cross NC logo, links for Shop Plans, Members, Providers, Employers, and Agents, a Contact Us link, a search icon, and a Log In button. The breadcrumb trail reads: Home > Providers > Prior authorization > Prior plan approval. The main heading is 'PROVIDERS' followed by 'Prior plan approval'. The content area explains that prior review (prior plan approval, prior authorization, prospective review or certification) is the process Blue Cross NC uses to review the provision of certain behavioral health, medical services and medications against health care management guidelines prior to the services being provided. It lists examples of services and procedures received on an outpatient basis, such as in a doctor's office, and prescription medications that may be subject to prior review. It also states that users can search for services and durable medical equipment, or medications that require authorization for all places of service, including when performed during any inpatient admission, including both planned inpatient admissions and emergent inpatient admissions. A list of reviews may confirm includes: Member eligibility, Benefit coverage, Compliance with Blue Cross NC corporate and Blue Medicare medical policies regarding medical necessity, Appropriateness of setting, Requirements for use of in-network and out-of-network facilities and professionals, and Identification of comorbidities and other problems requiring specific discharge needs.

# PEER-TO-PEER REQUESTS

- Process to review and discuss denied prior authorizations.
  - Must be requested before submitting claims.
- Required criteria:
  - Medical necessity adverse decision was received, along with health plan denial
  - Requested within two business days of the denial for inpatient or continued stay requests OR five business days for all other denials
  - Requested prior to an authorization
- Clinical discussion:
  - Facilitated within one business day of receipt of request
  - Our medical doctor makes two attempt to contact the rendering provider
  - A decision is rendered at the end of the call

# HOW TO REQUEST A PEER-TO-PEER

## Initiating Requests and Checking Statuses

### South Carolina Website

- Visit [www.SouthCarolinaBlues.com](http://www.SouthCarolinaBlues.com)  
Providers>Forms>Other Forms>Peer-to-Peer Request
- Enter all pertinent details (and save the document)
- Email the form to [Peer.Medical@bcbssc.com](mailto:Peer.Medical@bcbssc.com) or fax to 803-264-9175

### Phone (for statuses and eligibility only)

- Call 803-264-8114  
Available Monday - Friday  
8:30 a.m. – 5:00 p.m. EST

# UTILIZATION MANAGEMENT COURTESY RE-EVALUATIONS

- Utilization management courtesy re-evaluations are permitted for denials that are due to the following:
  - No clinical information submitted
  - Insufficient clinical information submitted
- To request a courtesy review, you must:
  - Specify the request is for a re-evaluation upon submission (via fax)
  - Submit clinical documentation within five business days of the denial notice



**THANK YOU**

