Ancillary Common Fee Schedule

And

Ambulatory Surgical Center Fee Schedule

Section
Ancillary Common Fee Schedule Program (ACFS)

The following information applies to ancillary providers with participation agreements that designate the ACFS as the contractual fee schedule. These participation agreements will generally have an exhibit titled “Ancillary Base Fee Schedule.” The number designation (code) for any of the codes listed in the ACFS are subject to modification (including addition, deletion, or combination of codes) as a consequence of periodic, published changes by Florida Blue, the AMA, CMS, or other nationally recognized sources. In the event that CPT/HCPCS codes are modified by a published change, a listing of each of the new and/or modified codes, and the corresponding base allowances will be supplied via the Florida Blue website no later than thirty days after implementation.

Some of the information contained in this guide may not apply to you if your services are being accessed by Florida Blue and its members through a management company or vendor arrangement (e.g., New Directions Behavioral Health or CareCentrix). Refer to your management company or vendor policies and procedures.

Terms and Definitions

The ACFS utilizes terminology that may be unfamiliar, so the following list consists of related terms and definitions:

- **Base Fee Schedule** – another name for ACFS.
- **Base Fee Schedule Allowance** – allowance assigned and established by Florida Blue to each procedure code contained on the ACFS. The allowance is not necessarily the same as the reimbursement rate. The reimbursement rate is based on the Contract Rates.
- **Contract Scope** – represents the covered services the provider has agreed to provide and Florida Blue has agreed to reimburse that are documented in the executed Contract.
- **Contract Rate(s)** – reimbursement rate negotiated and specified in the Contract, which may contain a single or multiple rates. To calculate the expected reimbursement rate for a service, the contracted rate is multiplied by the base fee schedule code allowance.
- **Not in Contract Scope** – services provided outside the contract scope. When a provider provides services to a member that are NICS, those services will be adjudicated in accordance with the terms and conditions of the Contract.
- **Service Block** – group of procedure codes categorized by Florida Blue. Florida Blue assigns each ACFS procedure code to a single service block. The service blocks are the same for all ancillary provider specialties and which codes are included in or excluded from a service block is at the sole discretion of Florida Blue and non-negotiable.
Ancillary Common Fee Schedules by Provider Type (Links to PDFs of fee schedules in red)

- Ambulance
- Ambulatory Infusion Services
- Behavioral Health
- Birthing Center
- Durable Medical Equipment
- Hearing Aid Dealer
- Independent Clinical Laboratory
- Independent Diagnostic Testing Center
- Rehabilitative Therapy
- Sleep Center
- Urgent Care Center

**Note:** The ACFS is subject to the terms and conditions of the applicable participation agreement, including established medical coverage guidelines, bundling guidelines, coding edits, and pricing rules. Reimbursement for covered services is determined by the member’s benefits that are applied to the negotiated contract allowance.
Calculating Allowed Amount

All payments are subject to the terms and limitation of the member’s contract and Florida Blue Medical Coverage Guidelines. The final payment for covered services is determined by the member’s benefits that are applied to the negotiated allowance. Additionally, the ACFS does not override established medical coverage guidelines, bundling guidelines, coding edits, and pricing rules.

The calculation formula is: \( A \times B = C \) or Base Fee Schedule Allowance (A) x Contract Rate (B) = Negotiated Contract Allowance (C)

**Note:** The allowance and rates contained in the following examples do not represent actual contracted allowances or rates. They are provided to assist in understanding how to calculate the negotiated allowed amount.

- **Example 1** - Negotiated contract rate of 75%

  CPT or HCPCS Procedure for Actual Pricing Base Fee Schedule Allowance (A) x Contract Rate (B) = Negotiated Contract Allowance (C)

  Standard example $100.00 75% 100 x 0.75 $75.00

- **Example 2** - Negotiated contract rate of 75% for MRI and 55% for general imaging (X-ray)

  CPT or HCPCS Procedure for Actual Pricing Base Fee Schedule Allowance (A) x Contract Rate (B) = Negotiated Contract Allowance (C)

  MRI $1000.00 75% 100 x 0.75 $750.00
  X-ray $100.00 55% 100 x 0.55 $55.00

- **Example 3** - Only contracted for negotiated contract rate of 55% for general imaging (X-ray) and 95% for mammography

  This example includes calculation for a Not in Contract Scope (NICS) service. The default reimbursement rate is 0% for Florida Blue’s NICS.

  CPT or HCPCS Procedure for Actual Pricing Base Fee Schedule Allowance (A) x Contract Rate (B) = Negotiated Contract Allowance (C)

  X-ray $100.00 55% 100 x 0.55 $55.00
  Mammography $615.00 95% 615 x 0.95 $584.25
  MRI $1000.00 0% for NICS 1000 x 0.75 $0.00
Ambulatory Surgical Center Program

Our Ambulatory Surgical Center FS program utilizes 16 all inclusive surgery categories to determine the allowed amount. All other services will deny as included in the surgery. Multiple surgery reductions are incorporated in the new program. In addition, the institutional correct coding initiative edits and medically unlikely edits apply to ASC payment programs. We will apply outpatient facility edits and not professional edits to ASCs.

The base fee schedule is the same for all ASC providers and for all lines of business, but the fee schedule reimbursement is calculated using the negotiated fee schedule percentage that is specific to each line of business.

There are no services defined to reimburse at a percent of charges and there is no capped payment under the new program. Implantable devices utilized in the performance of the surgery are not payable to the ASC. They must be obtained through the Implantable Device Procurement Program vendor which is the IPG.

The following information applies to ancillary providers with participation agreements that designate the (ACFS as the contractual fee schedule. These participation agreements will generally have an exhibit titled “Ancillary Base Fee Schedule.” The number designation (code) for any of the codes listed in the ACFS are subject to modification (including addition, deletion, or combination of codes) as a consequence of periodic, published changes by Florida Blue, the American Medical Association (AMA), CMS, or other nationally recognized sources. In the event that CPT/HCPCS codes are modified by a published change, a listing of each of the new and/or modified codes, and the corresponding base allowances will be supplied via Florida Blue’s website no later than thirty days after implementation.

For payment explanation and illustrative purposes, the following terminology and contractual references are used:

- **Fee Schedule Percent** - Refers to the outpatient fee schedule differential as defined in your Agreement.
- **Fee Schedule Surgery** - Outpatient fee schedule surgery services will be paid at the rate set forth in your Agreement.
  - Fee schedule amount x fee schedule percent
  - The rate includes payment for the complete course of treatment (e.g., holding room time, operating room time, anesthesia time, recovery room time, all drugs and supplies, laboratory studies, radiology studies, EKG, and other procedures performed.
Cap

Cap refers to maximum allowance as defined in your Agreement.

Cap payment applies to claims in which all procedures billed are reimbursed at approved charges multiplied by the non-fee schedule percent. The allowance is based on, whichever is less:

The cap amount, or approved charges $\times$ non-fee schedule percent.

- Cap is applied at the claim level.
- Cap applies to claims in which all procedures are paid at approved charges multiplied by the non-fee schedule percent.

Implants, prosthetics and orthotics are not subject to the cap.
Implant

Implant percent refers to the outpatient implantable device differential as defined in your Agreement.

Facilities with an agreement to procure implanted devices through a procurement service should follow instructions listed under the Implantable Device Procurement Program and should not include charges for the implanted device when billing Florida Blue.

Prosthetics, orthotics, and select implantable devices are reimbursed in addition to covered surgical procedures.

Reimbursement is as follows:

- Implants
  - Reported with revenue code 0275 (Pacemaker) or 0278 (Other Implants)
  - Allowance is based on approved charges multiplied by the implant percent
  - Implants are not subject to the cap
- Prosthetics and Orthotics
  - Reported with revenue code 0274 (Prosthetic/Orthotic Devices)
  - Allowance is based on approved charges multiplied by the non-fee schedule percent

Prosthetics and orthotics are not subject to the cap.
ASC Fee Schedule Allowance Calculation Examples

Amounts are displayed for illustrative purposes only. These examples demonstrate allowed amount calculations, not the Florida Blue payment because member deductible, coinsurance, and/or copayment liability have not been applied.

For the below examples, the following sample contracted percentage is used:

Fee schedule percent 100% (1.0)

Fee Schedule (FS) Surgery Example

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>CPT Code</th>
<th>Description</th>
<th>Schedule Type</th>
<th>Schedule Allowance</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0490</td>
<td>24515</td>
<td>Humeral Shaft Fracture</td>
<td>FS</td>
<td>$591</td>
<td>$800</td>
</tr>
</tbody>
</table>

Total Charges

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$800</td>
</tr>
</tbody>
</table>

The allowance is determined by:

Fee Schedule Allowance X Fee Schedule Percent = Allowance

24515   $591X 100% (1.0) = $591
## Surgery with Fee Schedule Ancillaries

<table>
<thead>
<tr>
<th>Revenue Code</th>
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<th>Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>0490</td>
<td>24515</td>
<td>Humeral Shaft Fracture</td>
<td>FS</td>
<td>$591</td>
<td>$800</td>
</tr>
<tr>
<td>0300</td>
<td>81000</td>
<td>Laboratory</td>
<td>FS</td>
<td>--</td>
<td>$25</td>
</tr>
<tr>
<td>0320</td>
<td>73060</td>
<td>Humerus x-ray</td>
<td>FS</td>
<td>--</td>
<td>$125</td>
</tr>
<tr>
<td>0324</td>
<td>71020</td>
<td>Chest x-ray</td>
<td>FS</td>
<td>--</td>
<td>$85</td>
</tr>
<tr>
<td>0730</td>
<td>93005</td>
<td>EKG</td>
<td>FS</td>
<td>--</td>
<td>$75</td>
</tr>
</tbody>
</table>

**Total Charges** $1100

The allowance is determined by:

\[
\text{Fee Schedule Allowance} \times \text{Fee Schedule Percent} = \text{Allowance}
\]

24515 \quad \$591 \times 100\% \times (1.0) = \$591

Fee Schedule Ancillaries are included in the surgery allowance.

81000 \quad \text{X Included in allowance}

73060 \quad \text{X Included in allowance}

71020 \quad \text{X Included in allowance}

93005 \quad \text{X Included in allowance}

**Total Allowance** $591

Cap does not apply
## Multiple Fee Schedule Surgery Examples

<table>
<thead>
<tr>
<th>Revenue Code</th>
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</thead>
<tbody>
<tr>
<td>0490</td>
<td>24515</td>
<td>Humeral Shaft Fracture</td>
<td>FS</td>
<td>$591</td>
<td>$800</td>
</tr>
<tr>
<td>0490</td>
<td>23650</td>
<td>Shoulder Dislocation</td>
<td>FS</td>
<td>$312</td>
<td>$300</td>
</tr>
<tr>
<td>0490</td>
<td>12005</td>
<td>Repair Laceration Scalp</td>
<td>FS</td>
<td>$419</td>
<td>$500</td>
</tr>
</tbody>
</table>

Total Charges $1600

The allowance is determined by:

Surgical Procedure with the highest fee schedule amount will have an allowance of 100 percent (1.0)

Fee Schedule Allowance X Fee Schedule Percent = Allowance

$24515 $591 X 100% (1.0) = $591

Additional procedures will have an allowance of 50 percent (.50) of the applicable fee schedule

$23650 $312 X 50% (.50) = $156

$12005 $419 X 50% (.50) = $209.50

Total Allowance $956.50
Outpatient Fee Schedule Program Example

Outpatient Fee Schedule reimburses by fee schedule for the majority of outpatient procedures reported, using HCPCS and CPT coding.

Covered outpatient services are reimbursed based on fee schedule, percentage of charge, or cap payment methodology, whichever is applicable under the specified Agreement.

The FROM DATE is used for all outpatient pricing calculations.

Amounts are displayed for illustrative purposes only. These examples demonstrate allowed amount calculations, not the Florida Blue payment because member deductible, coinsurance, and/or copayment liability have not been applied.

For the below examples, the following sample contracted percentages and cap are used:

- Fee Schedule (FS) Surgery
- Fee schedule percent 100% (1.0)
- Non-fee Schedule 50% (.50)
- Implant Percent 90% (.90)
- Cap $1,000

<table>
<thead>
<tr>
<th>Revenue Code</th>
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<tbody>
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<td>24515</td>
<td>Humeral Shaft Fracture</td>
<td>FS</td>
<td>$591</td>
<td>$800</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Charges</td>
<td></td>
<td></td>
<td>$800</td>
</tr>
</tbody>
</table>

The allowance is determined by:

Fee Schedule Allowance X Fee Schedule Percent = Allowance

24515  $591 X 100% (1.0) = $591

Cap does not apply when surgery is paid by fee schedule.
Outpatient Fee Schedule Surgery

Outpatient fee schedule surgery services will be paid at the rate set forth in your Agreement.

Fee schedule amount x fee schedule percent

The rate includes payment for the complete course of treatment (e.g. holding room time, operating room time, anesthesia time, recovery room time, all drugs and supplies, laboratory studies, radiology studies, EKG, and other procedures performed.

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<td>FS</td>
<td>$591</td>
<td>$800</td>
</tr>
<tr>
<td>0300</td>
<td>81000</td>
<td>Laboratory</td>
<td>FS</td>
<td>--</td>
<td>$25</td>
</tr>
<tr>
<td>0320</td>
<td>73060</td>
<td>Humerus x-ray</td>
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<td>--</td>
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<td>--</td>
<td>$85</td>
</tr>
<tr>
<td>0730</td>
<td>93005</td>
<td>EKG</td>
<td>FS</td>
<td>--</td>
<td>$75</td>
</tr>
</tbody>
</table>

Total Charges $1100

The allowance is determined by:

Fee Schedule Allowance X Fee Schedule Percent = Allowance

24515 $591 X 100% (1.0) = $591

Fee Schedule Ancillaries are included in the surgery allowance.

- 81000 -- X Included in allowance
- 73060 -- X Included in allowance
- 71020 -- X Included in allowance
- 93005 -- X Included in allowance

Total Allowance $591 Cap does not apply
Non-Fee Schedule Surgery

Non-fee schedule surgery is allowed at the approved charges multiplied by the non-fee schedule percent.

Covered ancillary services are allowed at (whichever is applicable) the:

Fee schedule amount x fee schedule percent or

Approved charges x non-fee schedule percent.

<table>
<thead>
<tr>
<th>Revenue Code</th>
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<th>Description</th>
<th>Schedule Type</th>
<th>Schedule Allowance</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0490</td>
<td>46255</td>
<td>Hemorrhoidectomy</td>
<td>FS</td>
<td>$479</td>
<td>$700</td>
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<tr>
<td>0370</td>
<td></td>
<td>Anesthesia</td>
<td>NFS</td>
<td>--</td>
<td>$300</td>
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<tr>
<td>0320</td>
<td></td>
<td>Recovery Room</td>
<td>NFS</td>
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<td>$150</td>
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<tr>
<td></td>
<td></td>
<td>Total Charges</td>
<td></td>
<td></td>
<td>$1150</td>
</tr>
</tbody>
</table>

The allowance is determined by:

Fee Schedule Allowance X Fee Schedule Percent = Allowance

46255 $479 X 100% (1.0) = $479

Ancillary services are included in the surgery allowance.

0370 -- X Included in allowance

0320 -- X Included in allowance

Total Allowance $479

Cap does not apply when surgery is paid by fee schedule.
Multiple Surgery Procedures

If more than one fee schedule surgery is performed, the surgical procedure with the highest fee schedule amount will be allowed at 100 percent; each additional fee schedule surgical procedure will be allowed at 50 percent of the fee schedule amount.

If both non-fee schedule surgery and fee schedule surgery are performed, all surgical procedures will be reimbursed at approved charges multiplied by the non-fee schedule percent.

Bilateral Surgery Billing

A surgery procedure code reported with a 50 modifier (i.e., bilateral procedure) is considered to be two procedures. Bilateral surgery may be reported either on a single line with a 50 modifier or on two separate lines without the 50 modifier.

Example without 50 Modifier; amounts shown are for illustrative purposes only.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>CPT Code</th>
<th>Description</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0360</td>
<td>19101</td>
<td>Biopsy of breast; open, incisional</td>
<td>$750</td>
</tr>
<tr>
<td>0360</td>
<td>19101</td>
<td>Biopsy of breast; open, incisional</td>
<td>$750</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>$1,500</td>
</tr>
</tbody>
</table>
Example with 50 Modifier, amounts shown are for illustrative purposes only

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>CPT Code</th>
<th>Description</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0360</td>
<td>19101 50</td>
<td>Biopsy of breast; open, incisional</td>
<td>$1,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

Non-Surgical Ancillary Services

Fee schedule, non-surgical (ancillary) services are reimbursed at the rate set forth in your Agreement.

Fee schedule amount x fee schedule percent

Non-fee schedule, non-surgical (ancillary) services are reimbursed at approved charges multiplied by the non-fee schedule percent.

Non-surgical claims include such services as:

- Laboratory
- Laboratory pathology
- Diagnostic and therapeutic radiology
- Nuclear medicine
- CT Scans and MRIs
- Emergency room, clinic, treatment room
- Pulmonary function
- Audiology
- Cardiology medicine
- EKG/ECG
- EEG
- Medical gastrointestinal services
Examples of items not considered for separate payment:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>CPT Code</th>
<th>Description</th>
<th>Schedule Type</th>
<th>Schedule Allowance</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0490</td>
<td>26531</td>
<td>MPJ, Arthroplasty</td>
<td>FS</td>
<td>$935</td>
<td>$1500</td>
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<tr>
<td>0278</td>
<td></td>
<td>Metacarpophalangeal Joint Implant</td>
<td>--</td>
<td>$800</td>
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<td></td>
<td></td>
<td>Total Charges</td>
<td></td>
<td></td>
<td>$2300</td>
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</tbody>
</table>

Facilities with an agreement to procure implanted devices through a procurement service should follow instructions listed under the Implantable Device Procurement Program, it should not include charges for the implanted device when billing Florida Blue.

The allowance is determined by:

**Step 1** Fee Schedule Allowance X Fee Schedule Percent = Surgery Allowance

\[
26531 \times \frac{935}{100} = 935
\]

**Step 2** Approved Charge X Implant Percent = Implant Allowance

\[
0278 \times \frac{800 \times 0.90}{100} = 720
\]

**Step 3** Surgery Allowance + Implant Allowance = Total Allowance

\[
935 + 720 = 1655
\]

Cap does not apply when any procedure is paid by fee schedule.
Implantable Device Procurement Program for Ambulatory Surgical Centers (ASC)

An Implantable Device Procurement Program was implemented and rolled out in a phased approach to all ASC networks. The program provides for the implementation of a new statewide implant device provider Implantable Provider Group, and includes changes in the ASC reimbursement model for implantable devices.

This program applies to all lines of business with the exception of Medicare Private Fee-for-Service and Medicare Supplement.

Implantable Provider Group (IPG) is the required resource for procuring, coordinating, billing, replacing and tracking implantable devices. ASCs will no longer bill Florida Blue for implantable devices used in surgeries. These devices will be billed to Florida Blue by IPG who will coordinate the device procurement process with you.

IPG is only providing device procurement services to contracted providers. Coverage under the member’s benefit plan will be determined by Florida Blue.

**Note:** Intraocular Lenses (IOLs) are excluded from the Implantable Device Procurement Program. ASCs should continue to supply and bill for IOLs under revenue code 276.

Process for Obtaining Implantable Devices from IPG

Complete an IPG New Account Form available at www.ipgsurgical.com/forms. This is a one-time process, which allows loading into the IPG system.

For questions on completing the form, participating providers should contact IPG.
Pre-Surgery

The ASC or the physician’s office fax’s the completed Patient Information Form to IPG at (866) 295-4773. You may substitute an existing Patient Demographic Form for IPG’s Patient Information Form providing your version contains the same information as required on the IPG form. If you choose this option, please have IPG review your format to confirm that it will work.

Forms are available at www.ipgsurgical.com/forms.

IPG confirms receipt via phone or email. IPG begins benefit verification process.

Device Approval and Scheduling

IPG provides written notification of acceptance via fax or email.

IPG sends a fax or email to the ASC confirming approval of the procedure.

Representative Delivery

(Manufacturer Representative brings implantable device to ASC)

Scheduling and Ordering: ASC schedules procedure and calls Manufacturer representative to deliver device. ASC notifies IPG of procedure.

Delivery: Contracted Manufacturer Representative delivers implantable device to ASC.

Post-Surgery: Manufacturer provides IPG with Implant Charge Sheet with administrator or physician’s signature and affixed implant stickers to IPG via fax at (866) 295-4773 within three days of the implant surgical procedure.

Note: Equipment lists with physician’s signatures submitted directly to ASC from Manufacturer Representative must be forwarded to IPG. IPG will not reimburse facility directly for implants.

Purchase: IPG issues Purchase Order to Manufacturer.

Billing and Payment: Manufacturer bills IPG directly. ASC has no financial responsibility for the implantable device.
Tissue Implant/Drop Ship Just-In-Time for Surgery

Scheduling: Physician’s office schedules procedure with ASC.

Purchase Order (PO): Physician’s office or facility obtains Tissue Request Form from IPG (available at www.ipgsurgical.com/forms). IPG then issues the physician’s office or facility a PO for the ordering of the implantable tissue.

Ordering: Physician’s office or facility orders implantable tissue from Contracted Tissue Bank.

Delivery: Tissue Bank ships implantable tissue to ASC.

Post-Surgery: ASC must submit an Implant Charge Sheet with administrator or physician’s signature and affixed implant stickers to IPG via fax at (866) 295-4773 within three days of the implant surgical procedure.

Billing and Payment: Tissue Bank bills IPG directly. ASC has no financial responsibility for the implantable tissue.

Purchased Inventory – ASC Maintains Inventory of Implants

Scheduling: ASC schedules and performs procedure using implantable device from purchased inventory.

Post-Surgery: ASC submits an Implant Charge Sheet with administrator or physician’s signature and affixed implant stickers to IPG via fax at (866) 295-4773 within three days of the implant surgical procedure.

Purchase: IPG provides ASC a PO allowing the ASC to order replacement items used in surgery.

Billing and Payment: Contracted Manufacturer bills IPG directly. ASC has no financial responsibility for the implantable device.

Delivery: Manufacturer ships implantable device directly to ASC to replenish the item used in surgery.
Consigned Shelf Stock – ASCMaintains Shelf Stock of Implants

Ordering: Manufacturer Representative provides sufficient stock of implants for shelf stock.

Post-Surgery: ASC submits an Implant Charge Sheet with administrator or physician’s signature and affixed implant stickers faxed to IPG via fax at (866) 295-4773.

Purchase Order: IPG will provide PO to contracted Manufacturer Representative.

Note: If ASC manages shelf stock, IPG will provide the ASC with a PO for ordering replenishment shelf stock from the contracted MFG.

Billing and Payment: Contracted Manufacturer bills IPG directly. ASC has no financial responsibility for the implantable device.

Delivery: Manufacturer Representative manages shelf stock levels/replenishment of consigned devices.

Non-Fee Schedule Surgery

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>CPT Code</th>
<th>Description</th>
<th>Schedule Type</th>
<th>Schedule Allowance</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0490</td>
<td>10061</td>
<td>I &amp; D Abscess</td>
<td>NFS</td>
<td>--</td>
<td>$450</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Charges</td>
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<td></td>
<td></td>
<td></td>
<td>$450</td>
</tr>
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</table>

The allowance is determined by the lesser of Cap dollar maximum $1,000 or Approved Charge X Non-Fee Schedule Percent = Allowance.

$450 X 50% (.50) = $225

$1000 > $225

Cap does not apply, as the approved charges multiplied by the non-fee schedule percent is the lesser.
Non-Fee Schedule Surgery and Fee Schedule Surgery

<table>
<thead>
<tr>
<th>Revenue Code</th>
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<th>Description</th>
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<th>Schedule Allowance</th>
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</tr>
</thead>
<tbody>
<tr>
<td>0490</td>
<td>46255</td>
<td>Hemorrhoidectomy</td>
<td>FS</td>
<td>$935</td>
<td>$1500</td>
</tr>
<tr>
<td>0490</td>
<td>10061</td>
<td>I &amp; D Abscess</td>
<td>NFS</td>
<td>--</td>
<td>$600</td>
</tr>
<tr>
<td>Total Charges</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$2100</td>
</tr>
</tbody>
</table>

When there is a combination of fee schedule surgery and non-fee schedule surgery, the allowance for all surgeries is based on the charges multiplied by the non-fee schedule percent.

The allowance is determined by the lesser of Cap dollar maximum $1,000 or:

Approved Charge X Non-Fee Schedule Percent = Allowance

$2100  X 50% (.50) = $1050

$1000 < $1050

Cap applies as the cap dollar maximum is the lesser of.
## Non-Fee Schedule Surgery with Implant

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>CPT Code</th>
<th>Description</th>
<th>Schedule Type</th>
<th>Schedule Allowance</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0490</td>
<td>33216</td>
<td>Replacement of Pacemaker Pulse Generator</td>
<td>NFS</td>
<td>--</td>
<td>$2200</td>
</tr>
<tr>
<td>0275</td>
<td>L8499</td>
<td>Pacemaker</td>
<td>--</td>
<td>--</td>
<td>$3500</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Total Charges</strong></td>
<td></td>
<td></td>
<td>$5700</td>
</tr>
</tbody>
</table>

Facilities with an agreement to procure implanted devices through a procurement service should follow instructions listed under the Implantable Device Procurement Program and should not include charges for the implanted device when billing Florida Blue.

The allowance is determined by:

**Step 1** Surgery Allowance the lesser of Cap dollar maximum $1,000 or:

Approved Charge X Non-Fee Schedule Percent = Surgery Allowance

$2200 \times 50\% \times 0.50 = $1100

$1,000 < $1,100

Cap applies

**Step 2** Implant Allowance

Implant Charge X Implant Percent = Implant Allowance

$3500 \times 90\% \times 0.90 = $3150

**Step 3** Total Allowance

Surgery Allowance + Implant Allowance = Total Allowance

$1000 + $3150 = $4150
## Non-Fee Schedule Surgery with Fee Schedule and Non-Fee Schedule Ancillaries

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>CPT Code</th>
<th>Description</th>
<th>Schedule Type</th>
<th>Schedule Allowance</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0490</td>
<td>10061</td>
<td>Replacement of Pacemaker Pulse Generator</td>
<td>NFS</td>
<td>--</td>
<td>$450</td>
</tr>
<tr>
<td>0370</td>
<td></td>
<td>Anesthesia</td>
<td>NFS</td>
<td>--</td>
<td>$125</td>
</tr>
<tr>
<td>0300</td>
<td>85025</td>
<td>CBC</td>
<td>FS</td>
<td>$20</td>
<td>$85</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Total Charges</strong></td>
<td></td>
<td></td>
<td><strong>$660</strong></td>
</tr>
</tbody>
</table>

The allowance is determined by:

**Step 1**  
Approved Charges X Non-Fee Schedule Percent = Non-Fee Schedule Allowance

10061 $450 X 50% (.50) = $225  
0370 $125 X 50% (.50) = $62.50

$287.50

**Step 2**  
Fee Schedule Allowance X Fee Schedule Percent = Fee Schedule Allowance

85025 $20 X 100% (1.0) = $20

**Step 3**  
Non-Fee Allowance + Fee Schedule Allowance = Total Allowance

$287.50 + 20 = $307.50

Cap does not apply when any procedure is paid by fee schedule.
**Fee Schedule and Non-Fee Schedule Surgeries with Fee Schedule Ancillary**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>CPT Code</th>
<th>Description</th>
<th>Schedule Type</th>
<th>Schedule Allowance</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0490</td>
<td>46255</td>
<td>Hemorrhoidectomy</td>
<td>FS</td>
<td>$635</td>
<td>$700</td>
</tr>
<tr>
<td>0490</td>
<td>10061</td>
<td>I &amp; D Abscess</td>
<td>NFS</td>
<td>--</td>
<td>$450</td>
</tr>
<tr>
<td>0300</td>
<td>81000</td>
<td>Laboratory</td>
<td>FS</td>
<td>$15</td>
<td>$50</td>
</tr>
<tr>
<td>0324</td>
<td>71020</td>
<td>Chest X-ray</td>
<td>FS</td>
<td>$25</td>
<td>$75</td>
</tr>
<tr>
<td><strong>Total Charges</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>$1275</strong></td>
</tr>
</tbody>
</table>

When there is a combination of fee schedule surgery and non-fee schedule surgery, the allowance for all surgeries is based on the charges multiplied by the non-fee schedule percent.

The allowance is determined by:

**Step 1**  
Approved charges X Non-Fee Schedule Percent = Non-Fee Schedule Allowance

- 46255  
  $700 X 50% (.50) = $350
- 10061  
  $450 X 50% (.50) = $225

$575

**Step 2**  
Fee Schedule Allowance X Fee Schedule Percent = Fee Schedule Allowance

- 81000  
  $15 X 100% (1.0) = $15
- 71020  
  $25 X 100% (1.0) $25

$40

**Step 3**  
Non-Fee Allowance + Fee Schedule Allowance = Total Allowance

$575 + $40 = $615

Cap does not apply when any procedure is paid by fee schedule.
## Fee Schedule and Non-Fee Schedule Surgeries with Non-Fee Schedule Ancillary

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>CPT Code</th>
<th>Description</th>
<th>Schedule Type</th>
<th>Schedule Allowance</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>0490</td>
<td>46255</td>
<td>Hemorrhoidectomy</td>
<td>FS</td>
<td>$935</td>
<td>$1500</td>
</tr>
<tr>
<td>0490</td>
<td>10061</td>
<td>I &amp; D Abscess</td>
<td>NFS</td>
<td>--</td>
<td>$450</td>
</tr>
<tr>
<td>0270</td>
<td>--</td>
<td>Med-Surg Supplies</td>
<td>NFS</td>
<td>--</td>
<td>$125</td>
</tr>
<tr>
<td><strong>Total Charges</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>$2075</strong></td>
</tr>
</tbody>
</table>

When there is a combination of fee schedule surgery and non-fee schedule surgery, the allowance for all surgeries is based on the charges multiplied by the non-fee schedule percent.

The allowance is determined by the lesser of Cap dollar maximum $1,000 or Approved Charges X Non-Fee Schedule Percent = Allowance

\[
\$1500 \times 50\% \times (0.5) = \$750
\]

\[
\$450 \times 50\% \times (0.5) = \$225
\]

**Total $1037.50  $1000 < $1037.50**

Cap applies because all lines are reimbursed by charges multiplied by non-fee schedule percent.