# IMPORTANT INFORMATION REGARDING THE USE OF THIS MANUAL

INTERNATIONAL PROVIDER HANDBOOK

# IMPORTANT NEWS AND UPDATES

Provider Newsletters

Health Care Reform

# FREQUENTLY REFERENCED SECTIONS

myBlue

Ancillary Common Fee Schedule Section *

Self Service Section

Standing Authorization Section

Utilization Management Section

# PROVIDER DATA AND DEMOGRAPHIC MAINTENANCE

Proactive and Timely Update of Your Provider Records

Need to Register with Availity?

# CONTACT US

Contingency Plan for Emergencies and Natural Disasters

# JOIN OUR NETWORKS

Our Networks

Register with Us

The Credentialing Process

Credentialing Requirements for Advanced Non-Physician Practitioners

# OUR PRODUCTS

Commercial Products

Federal Employee Plan (FEP) Plan Options

State Employee PPO

Medicare Products

MedAdvantage/BlueMedicare HMO/PPO Product

Medicare Supplement Products-Advantage 65

Blue Medicare Premier HMO

# GLOBAL PLANS FOR GROUP BUSINESS

BCBS Global Expat

BCBS Global Traveler

# HEALTH CARE IDENTIFICATION CARDS

ID Cards
State Employee ID.................................................................................................................41
Federal Employee Program (FEP) ID........................................................................................42
Medicare ID Cards.................................................................................................................43

UTILIZATION MANAGEMENT PROGRAMS......................................................... 48
Authorization Guidelines .....................................................................................................51
Referral Guidelines ..............................................................................................................51

PHARMACY UTILIZATION MANAGEMENT GUIDELINES.............................. 52

VOLUNTARY PREDETERMINATION FOR SELECT SERVICES (VPSS) GUIDELINES................................................................. 54

CLAIMS PROCESS........................................................................................................ 56
Physician Extenders............................................................................................................57
Pharmacy Claim (Medical)....................................................................................................64

HIPAA VERSION 5010 UPDATES AND HELPFUL TIPS................................. 66

BILLING GUIDELINES................................................................................................. 67

DOCUMENTATION OF CARE REVIEW................................................................. 68
Guidelines for Primary Care Physician Medical Record Review......................................68

MEDICAL PHARMACY SERVICES ........................................................................ 70

REIMBURSEMENT EXCEPTION DRUG PRICING - UNCLASSIFIED DRUG PAYMENT POLICY ................................................................. 70
Claim Payments and Statements .......................................................................................77

SUBROGATION AND COORDINATION OF BENEFITS .................................. 81
Coordination of Benefits with Medicare Group Plans......................................................87

APPEALS....................................................................................................................... 91

PROVIDER APPEALS................................................................................................. 93
Clinical Appeals..................................................................................................................94
Non-Clinical Appeals.........................................................................................................94
Administrative Appeals.....................................................................................................95
Important Information Regarding the Use of this Manual

Welcome to the Florida Blue Manual (Blue Cross and Blue Shield of Florida, Inc.) or Florida Blue HMO (Health Options, Inc.) for Physicians and Providers. The Manual is for physicians, hospitals, ancillary providers and facilities participating in any Florida Blue network. We realize the administrative requirements of managing a member’s health care can be complex; this Manual was developed to assist in understanding requirements and serve as a resource for answering questions you may have about our networks, products, programs, and coding and claims filing guidelines.

The Manual is not intended to be a complete statement of polices or procedures for providers. Other policies and procedures, not included in this manual, may be posted on our website or published in special publications, including but not limited to, letters, bulletins, or newsletters.

Any section of this Manual may be updated at any time. Florida Blue may notify providers of updates in a variety of ways, depending upon the nature of the update, including mailings, publication in BlueLine, our provider newsletter, or posting to our website at www.floridablue.com.

In the event of any inconsistency between information contained in this Manual and the agreement(s) between you or your facility and Florida Blue or Florida Blue HMO the terms of such agreement(s) shall govern (referred to herein as your “Agreement”). Also, please note that at various times when dealing with Florida Blue, other Blue Cross and/or Blue Shield Plans, you may be provided with available information concerning an individual's status, eligibility for benefits, and/or level of benefits. The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits. Payment shall only be made in accordance with the applicable benefit plan in the individual’s actual eligibility as determined by such benefit plan, further the presentation of Florida Blue identification cards in no way creates, nor serves to verify an individual's status or eligibility to receive benefits.

Providers are encouraged to conduct business with us electronically through Availity, whenever possible.

Please note that we may change the location of a website, a benefit plan name, branding or the customer identification card identifier. If and when these changes occur and apply to you, we will communicate such changes to you.
Important News and Updates

Doing business with us is easier and faster than ever when you take advantage of the wealth of information and resources available to you online. Stay up-to-date on our latest products and programs and process changes by simply accessing bulletins, newsletters and other valuable resources and tools available on our website at www.floridablue.com.

Provider Newsletters

While you are on our website, we encourage you to sign up for Bluemail, our provider email communication which provides many benefits including:

- Receiving important, timely information by email at your desktop
- Tracking, reading and saving information electronically and retrieving it easily when needed
- The ability to forward important information to others in the office

Health Care Reform

The Affordable Care Act (ACA) provides for the creation of Marketplaces (Exchanges) for individuals to purchase health insurance. Florida Blue Marketplace plans are based on existing product portfolios and use existing provider network arrangements such as BlueOptionsSM (NetworkBlue), BlueCare® (Health Options, Inc.) and BlueSelect. Your participation in our Marketplace products depends on whether you participate in a network that supports such products.

As a reminder, per your Agreement(s) with Florida Blue and/or Florida Blue HMO (Health Options, Inc.) you have agreed to see our members who are enrolled in a product that uses a network in which you participate. As such, you are not permitted to exclude members from service because they enrolled in our products through the Marketplace.

For more information go to http://hcr.floridablue.com/
Frequently Referenced Sections

For your convenience, some of the more frequently referenced policies and guidelines have been migrated into separate appendices for ease of access and easier print capability. These appendices are part of the Manual and you must comply with such provisions as may be set forth in your participating provider agreement with us. We may make changes to such appendences from time to time, and to the extent required under your Agreement, we will provide you with notice of any such changes.

myBlue

Ancillary Common Fee Schedule Section *

Billing Guidelines

Self Service Section

Standing Authorization Section

Utilization Management Section

*Choose applicable fee schedule based on provider type
Provider Data and Demographic Maintenance

This section of the Manual outlines various processes for reviewing and maintaining your Provider Data record at Florida Blue.

Providers should conduct business with us electronically through Availity. To use our self-service tools you need only register with Availity and define your users, in addition to yourself. When you register for Availity, you will be given the administrator role and can perform all functions (including receiving notifications related to your data). You may also register additional users. We are serious about protecting your data and have additional security around the ability to view and update your records. As an administrator you have access to this – but make sure you request the Provider Data - 720 Role for additional users in your office that make updates to provider data.

Refer to the Self-Service Tools Frequently Accessed Section for additional information about Availity.

Proactive and Timely Update of Your Provider Records

As you know, provider demographic data is at the core of doing business with you. It impacts claim payments (timeliness and accuracy) our provider directories (how our members find you) and how you request and receive referrals and authorizations for the care of your patients (our members). Florida Blue providers are contractually required to report all changes of address or other practice information electronically. Providers must notify us 30-days prior to the effective date of any changes to ensure accurate information is displayed on the provider directory and to avoid impacts to claims processing.

We have enabled the ability for you to view and manage your provider record real time in Availity. To make changes to office and/or billing information, including information contained in the provider directory, complete the Provider Information Update Form. Once in Availity you will need to go to Florida Blue Payer Spaces, View and Manage Your Record. You may also submit changes online through our Provider Directory which will route you to Availity.

- You must review and validate your information no less than quarterly, as required by the Centers for Medicare & Medicare Services (CMS). CMS now requires quarterly validation of participating provider information. Make sure we have your correct address, telephone number, email address and ability to accept new patients (see below). When you log into Availity you will see notifications in your mailbox. Open your Provider Data Update notification and access your record by following the link on the Availity Notification. Use the FB ID # along with the corresponding TIN for the provider you wish to update.

The key demographic content (see below) must be reviewed and validated quarterly. Key demographic content, some of which are also displayed on the Find a Doctor (online provider directory) tools consists of:

- Name
- Service location,
- Hours of operation
- Accessibility
- Hospital privileges
- Website URL (if you have one)
- Accepting new patients (panel status)
- Languages spoken (by office and physician)
- Appointment telephone number
- If provider is still participating with the group (group affiliation)
- Provider data administrator email address
- Covering physicians

**Need to Register with Availity?**

To use our self-service tools you need only register with Availity at Availity.com and define your users, in addition to yourself. When registering, you will be given the *administrator* role and can perform all functions (including receiving notifications related to your data). You may also register additional users. We are serious about protecting your data and have additional security around the ability to view and update your records. As an administrator you have access for this – but make sure you request the 720 role for the users who will be responsible for maintaining the accuracy of your profile.
Contact Us

The Quick Reference Contact Guide, found on the Contact Us page at www.floridablue.com, provides updated contact information for Florida Blue and Florida Blue Partners.

Contingency Plan for Emergencies and Natural Disasters

During a national/statewide emergency or natural disaster make every reasonable attempt to follow normal business procedures. In the event, you are unable to adhere to those procedures, follow the guidelines below:

- Attempt to contact the Provider Contact Center
- If you are unable to verify member eligibility and benefits by phone or electronically through Availity:
  - Accept a valid Florida Blue identification card (ID) and picture ID, or
  - Accept a Florida Blue universal application, acknowledgement/acceptance letter and picture ID
JOIN OUR NETWORKS

Florida Blue and Florida Blue HMO have several networks available to licensed providers that meet our contracting criteria and network needs. Participation in one network does not automatically mean that the provider participates in every network. Each network may correlate to multiple products; refer to your Florida Blue and or Florida Blue HMO provider Agreement to confirm your network participation.

Providers participating in our networks are reimbursed based on the terms of their Agreement for services to eligible members and have agreed to accept the Florida Blue allowed amount (less deductibles, coinsurance, and/or copayments) as payment-in-full for covered services. When members access participating providers, covered benefits are typically reimbursed at a higher benefit level, and their out-of-pocket costs are usually lower.

Physicians and providers are selected to participate in our networks based on an assessment and determination of the network’s needs. To be considered for participation you must be a registered provider with us. If you are not currently registered, complete the registration process prior to moving forward with your request to participate.

To be considered for participation you must be a registered provider with Florida Blue. If you are not currently registered with Florida Blue, you must complete the registration process prior to moving forward with your request to participate in our Networks. To become a registered provider, complete the Provider Registration Form.

Some of our provider networks may be closed or open only in limited areas. Prior to moving forward, refer to the Network Status section to determine if we are currently accepting new requests.

If You are currently a registered provider with Florida Blue or have gone through the registration process and wish to be considered for participation in our network(s), complete the Request to Join our Networks form.

Our Networks

Each Florida Blue and Florida Blue HMO network may correlate to multiple products; outlined are Florida Blue products and the corresponding provider Agreements (Insurance Base Contract or Health Options) and networks with checked boxes, use the Our Networks Table to understand how each network is associated to our products.

Some of our provider networks may be closed or open only in limited areas. Prior to moving forward, refer to the Network Status Table to determine if we are currently accepting new requests. Refer to your service type to determine if the network is open. If the network for your service type is open, complete the Join our Network request form.

Note: Providers must register with us in order to submit a request to participate. If you are not a registered provider, complete the Provider Registration Form. Once registered you may then complete the Join our Network form.
If the network is listed as closed, unless we inform you otherwise, you may check back with us periodically as we are constantly evaluating our networks needs and the open/closed status is subject to change.

The availability of health plans from Florida Blue and its affiliates vary by county. To see which health plans are available by county, please click the link below that applies to you.

**Employer Provided Health Plans by County**

**Individual & Family Health Plans by County**

The availability of health plans from Florida Blue and its affiliates vary by county. To see which county myBlue is in, please click the link.

**myBlue Individual and Family Health Plan by County**
Register with Us

All providers must register with us to enable the credentialing process. To register please complete the Provider Registration Form. The form includes instructions on how to complete and submit the form.

The Credentialing Process

The verification of credentials is an integral part of our network process. It helps ensure our members have access to quality care and it is also required to meet both state and federal guidelines. Completion and submission of the application and the required documentation does not guarantee inclusion in any of our network(s).

We currently use Council for Affordable Quality Healthcare (CAQH) as our preferred method of application data; please ensure that your current CAQH is complete and accurate, as well as currently attested. This will help facilitate the credentialing verification process. We currently utilize a vendor, Medversant, to perform the credentialing verification process and Medversant will access your CAQH application or contact you regarding completion of a manual application if you do not use CAQH. We highly recommend that you consider using CAQH as it will make the credentialing and re-credentialing process much easier. If additional application information is needed, you may be contacted by Medversant on behalf of Florida Blue. Be sure to comply with any response for additional credentialing information timely to ensure the application process is not delayed. We reserve the right to change the vendor we use as we see fit.

Ancillary Facility/Supplier Businesses and Ambulatory Service Centers (ASC) are not required to use CAQH and should complete and submit a credentialing application and will be sent to you only upon receipt of your request to participate. Along with the application, additional documentation is required by Florida Blue and varies depending on provider type and services to be rendered.

Note: Applications must be fully completed and all documentation received by us to start the process of credentialing.
Credentialing Requirements for Practitioners

Providers must register with us in order to initiate the credentialing process. To register, complete the Provider Registration Form. Upon completion of the registration you will be given the opportunity to complete a request to join our networks. Please wait and complete the request, this initiates the credentialing process. If already registered please submit a Join our Network request form.

Ancillary Facility/Supplier Businesses and ASCs should complete and submit a credentialing application. The application will be sent to you once your network participation request is reviewed.

Physicians must complete an application directly through the CAQH Universal Credentialing DataSource. Go to www.caqh.org/ucd_physician_faq.php for detailed information on how to create/edit your application with CAQH and to obtain a CAQH number.

Required documentation below must be faxed to CAQH at (866) 293-0414.

- Signed attestation statement (within 180 days)
- Copy of Florida license(s)
- Education and training, if applicable
- Work history for the past five years (explain gap of 6 + months)
- Copy of specialty board certificate, if applicable
- Hospital admitting privileges, if applicable
- Current certification of insurance (face sheet with expiration date and coverage amounts)
- Explanations for any malpractice history and disciplinary actions
- Copy of applicable certification(s), e.g., board certification, if applicable
- Explanations for any health issues
- Copy of Drug Enforcement Administration (DEA) license, if applicable
Credentialing Requirements for Advanced Non-Physician Practitioners

We currently define Advanced Non-Physician Practitioners (ANPP), Advanced Practice Registered Nurse (APRN), Certified Nurse Midwives (CNMs), Clinical Nurse Specialist (CNSs), Physician Assistants (PAs), and Registered Nurse First Assistant (RNFAQs) who practice independently or as associated members of a physician association. Florida Blue may expand this definition in the future to include other provider types.

Advanced Non-Physician Practitioners, as defined above, are required to obtain a Florida Blue provider number, and register their National Provider Identifier (NPI) number with Florida Blue.

It is the physician’s, physician groups, or facility’s responsibility to ensure that any employed or contracted Advanced Non-Physician Practitioners are properly licensed and supervised as may be required by law including, but not limited to Florida Statutes 458.347 (1) (f) and 464.012. They are also responsible for ensuring that employed Advanced Non-Physician Practitioners maintain proper licenses and credentials. Additionally, they must ensure that each Advanced Non-Physician Practitioner is registered.

Credentialing Requirements Ancillary Facility/Supplier Business

In addition to a completed application you will be asked to submit the following, if applicable:

- Signed attestation statement (within 180 days)
- Copy of Florida license(s)
- Copy of Florida registration
- Current certification of insurance (face sheet with expiration date and coverage amounts) to include errors and omissions for General and Professional liability. If the insurance certificate covers multiple locations, it should either state that all locations owned by the corporate entity are covered OR have a roster of all covered locations attached.
- Explanations for malpractice history and disciplinary actions
- Copy of accreditation documentation, if applicable (ASCs must be accredited)
- If performing MRI, CT, PET, NC (includes cone bean CT)- The Joint Commission, IAC or ACR accreditation is required
- If performing mammography services, ACR Accreditation is Required
- Copy of applicable certification(s)
- Supervising physician statement, if applicable
- Copy of facility medical director’s curriculum vitae, medical license, DEA certificate – if applicable
- Copy of Medicare certification(s), if applicable
- Copy of Medicare participation letter, if applicable
- AHCA and/or Centers for Medicare & Medicaid Services (CMS)/Medicare site survey. If not obtained, a Florida Blue site visit is required. (Within 36 months prior to Credential Committee)
Credentialing Requirements for Advanced Non-Physician Practitioners

We currently define Advanced Non-Physician Practitioners (ANPP), Advanced Practice Registered Nurse (APRN), Certified Nurse Midwives (CNMs), Clinical Nurse Specialist (CNSs), Physician Assistants (PAs), and Registered Nurse First Assistant (RNFAs) who practice independently or as associated members of a physician association. Florida Blue may expand this definition in the future to include other provider types.

Advanced Non-Physician Practitioners, as defined above, are required to obtain a Florida Blue provider number, and register their National Provider Identifier (NPI) number with Florida Blue.

It is the physician’s, physician groups, or facility’s responsibility to ensure that any employed or contracted Advanced Non-Physician Practitioners are properly licensed and supervised as may be required by law including, but not limited to Florida Statues 458.347 (1) (f) and 464.012.. They are also responsible for ensuring that employed Advanced Non-Physician Practitioners maintain proper licenses and credentials. Additionally, they must ensure that each Advanced Non-Physician Practitioner is registered.

Re-credentialing

Re-credentialing is performed every three years or as otherwise required by law or applicable regulations, and requires the submission of an updated credentialing application and documentation.

Hospitals are evaluated annually for state license, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation, Det Norske Veritus (DNV) accreditation, Medicare certification, and sanction information. Site visits are conducted for non-accredited hospitals.

Failure to supply all requested documentation may result in the termination of your contract by Florida Blue.

Updating Application/Documentation

Providers have the right to review, correct and resubmit any of the information to support their credentialing application including but not limited to third party sources. Corrections must be submitted by the date requested and in all cases no later than the completion date of the credentialing process. Delays in returning materials may result in request for closure or termination of your contracts. Providers have the right to obtain status of their application and information shared with Practitioners may include information obtained to evaluate their credentialing application, attestation or curriculum vita (CV).

Note: Participating hospital based physicians who practice exclusively in the hospital, skilled nursing facility and/or ambulatory service center settings are required to meet Florida Blue’s credentialing requirements established under their respective contractual agreements. This credentialing requirement is typically met by fulfilling the requirements for being on staff where they provide services as long as the facility meets our credentialing requirements. The facility is required to be credentialed by us. If this requirement is not met, and or if any services are provided by a physician outside the above settings, then the physician is required to go through our credentialing process to participate in our networks.
Awaiting an Answer

Completed applications are verified and a decision is made for participation with Florida Blue. Each applicant will receive a written response regarding contracting status.

The following are circumstances which will delay your answer:

- Incomplete applications (all questions must have an answer, even if the answer is only N/A)
- Incomplete documentation
- Expired documentation

Note: If you have completed and submitted all required documentation and haven’t received any communication within 90-days, you may contact our Network Management area who can help you with the process.
Our Products

Commercial Products

Florida Blue (Blue Cross and Blue Shield of Florida, Inc.) and its affiliate, Florida Blue HMO (Health Options, Inc.), offer a variety of products with network configurations to meet our member needs for coordination of care and greater affordability. We have a variety of products for individuals, small groups, and large groups on a fully insured and self-funded basis. These products may or may not require members to select a Primary Care Physician (PCP), may or may not have out-of-network benefits and may include broad or narrow network of participating providers.

Our products and services are continually evolving to ensure we stay true to our mission, to help people and communities achieve better health. Coverage can also be purchased through the individual or small group Health Insurance Marketplaces.

Visit www.floridablue.com for more information about our products in your area. If a member presents an identification card (ID) with a product name with which you are not familiar, please contact our Provider Contact Center at the number on the back of the member's health care ID card.

We are committed to offering quality health care coverage, as well as maintaining the dignity and integrity of our members, we do not discriminate against members based on race, sex, color, creed, national origin, gender, sexual orientation, gender identity, age, disability or marital status.

The availability of health plans from Florida Blue and its affiliates vary by county. To see which health plans are available by county, please click the link below that applies to you.

Employer Provided Health Plans by County

Individual & Family Health Plans by County

myBlue

Florida Blue is offering a new product, myBlue HMO, targeted for individual Under 65 consumers who are eligible to purchase insurance online through the Health Insurance Exchange. myBlue is a tightly-managed and referral-based product that will tightly control care through a gatekeeper primary care model.

For more information about the myBlue product please access the myBlue Manual for Physicians and Providers. We have affordable plans for everyone and every budget.

The availability of health plans from Florida Blue and its affiliates vary by county. To see which county myBlue is in, please click the link.

myBlue Individual and Family Health Plan by County
The table(s) below provides information about the most common Florida Blue (Blue Cross and Blue Shield of Florida, Inc.) and its affiliate, Florida Blue HMO (Health Options, Inc.) Commercial products; the list is provided for your convenience and is subject to change.

<table>
<thead>
<tr>
<th>Product Name:</th>
<th>Network</th>
<th>How do members access physician and health care professionals?</th>
<th>Is specialist referral required?</th>
<th>Is the treating physician and/or facility required to give notice when providing certain services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueCare</td>
<td>Florida Blue-HMO</td>
<td>Members choose, or are assigned a primary care physician (PCP) for every family member from the network of participating physicians. Member is encouraged to see their PCP to coordinate their care, but is not required to obtain PCP referral when accessing a specialist or facility for care. BlueCare does not cover Out-of-network services (except for emergency care, unless the member has an out-of-network rider with their plan. No authorization for these services is required as long as the services are covered under the rider. To determine if the member has out-of-network coverage, look for &quot;OON Rider&quot; under the member number on the identification (ID) Card.</td>
<td>Referrals are not required for office visits to participating providers. The following physical therapy services are ineligible for payment to participating PCPs when performed in a physician’s office: Physical Medicine and Rehabilitation: 97001 – 97546.</td>
<td>Yes, on selected procedures and services, See guidelines in the Utilization Management section of this Manual.</td>
</tr>
<tr>
<td>Product Name:</td>
<td>Network</td>
<td>How do members access physician and health care professionals?</td>
<td>Is specialist referral required?</td>
<td>Is the treating physician and/or facility required to give notice when providing certain services?</td>
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<tr>
<td>BlueChoice</td>
<td>Florida Blue-Preferred Patient Care (PPC)</td>
<td>BlueChoice members have open access to any PPC provider without designating a primary care physician. Most BlueChoice plans allow members to seek out-of-network services from providers participating in the Traditional/PPS/PHS network. Covered benefits may be reimbursed at a lower non-participating level. Participating Traditional/PPS/PHS are considered out-of-network for PPC members, however, you may not balance bill the member.</td>
<td>No, referrals to specialists are not required.</td>
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</tr>
<tr>
<td>BlueOptions</td>
<td>Network Blue-PPO</td>
<td>BlueOptions members have open access to any PPC provider without designating a primary care physician. Most BlueOptions plans allow members to seek out-of-network services from providers participating in the Traditional/PPS/PHS network. Covered benefits may be reimbursed at a lower non-participating level. Participating Traditional/PPS/PHS providers are considered out-of-network for PPC members, however, you may not balance bill the member.</td>
<td>No, referrals to specialists are not required.</td>
<td>Yes, on selected procedures and services, See guidelines in the Utilization Management section of this Manual.</td>
</tr>
<tr>
<td>Product Name: Traditional PPS/PHS</td>
<td>Network</td>
<td>How do members access physician and health care professionals?</td>
<td>Is specialist referral required?</td>
<td>Is the treating physician and/or facility required to give notice when providing certain services?</td>
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<td></td>
<td>Payment for Professional Services (PPS)</td>
<td>Traditional PPS/PHS members have open access to any BlueSelect provider without designating a primary care physician. Members may receive care from providers who participate in Florida Blue networks but may be subject to higher out-of-pocket costs. Members also have access to the Traditional/PPS/PHS network. When members access Traditional/PPS/PHS providers, covered benefits are usually reimbursed at a lower level and their coinsurance percentage is higher. As a participating Traditional/PPS/PHS network provider, you may not balance bill the member.</td>
<td>No, referrals to specialists are not required.</td>
<td></td>
</tr>
<tr>
<td>Product Name:</td>
<td>Network</td>
<td>How do members access physician and health care professionals?</td>
<td>Is specialist referral required?</td>
<td>Is the treating physician and/or facility required to give notice when providing certain services?</td>
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<tr>
<td>BlueSelect</td>
<td>BlueSelect</td>
<td>BlueSelect members have open access to any BlueSelect provider without designating a primary care physician. However certain services are subject to an Exclusive Provider Organization (EPO) provision and are only covered when rendered by providers designated by us as the exclusive provider for such service. Services that may be subject to the EPO provision are: Behavioral Health Dental services Durable Medical Equipment Home health/home infusion Laboratory Medical Supplies Orthotics/prosthetics Pharmacy Vision Services Participating Traditional (PPS/PHS) hospitals and facilities are considered out-of-network for BlueSelect members, and there is no balance billing protection.</td>
<td>No, referrals to specialists are not required.</td>
<td>Yes, on selected procedures and services, See guidelines in the Utilization Management section of this Manual.</td>
</tr>
<tr>
<td>Product Name: SimplyBlue</td>
<td>Network: Florida Blue – HMO</td>
<td>How do members access physician and health care professionals?</td>
<td>Is specialist referral required?</td>
<td>Is the treating physician and/or facility required to give notice when providing certain services?</td>
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<tr>
<td>simplyBlue uses a subgroup of our BlueCare® HMO (Health Options, Inc.) primary care physicians and specialists network.</td>
<td>All BlueCare HMO providers in the counties where the new product is available can see SimplyBlue members unless they receive a letter from Florida Blue notifying them that they are not participating with SimplyBlue.</td>
<td>Members choose, or are assigned a primary care physician (PCP) for every family member from the network of participating physicians. Member is encouraged to see their PCP to coordinate their care, but is not required To obtain PCP referral when accessing a specialist or facility for care. SimplyBlue does not cover Out-of-network services. (except for emergency care)</td>
<td>Referrals are not required for office visits to participating providers. The following physical therapy services are ineligible for payment to participating PCPs when performed in a physician's office: Physical Medicine and Rehabilitation: 97001 – 97546.</td>
<td>Yes, on selected services. See guidelines Utilization Management section of this Manual.</td>
</tr>
</tbody>
</table>
Federal Employee Plan (FEP) Plan Options

Florida Blue (Blue Cross and Blue Shield of Florida, Inc.) is the servicing agent for the Federal Employee Service Benefit Plan. This is a fee-for-service plan with a preferred provider organization (PPO) that provides health care benefits to federal employees, retirees, surviving spouses and eligible dependents in Florida. FEP contract numbers begin with the letter “R” followed by eight numeric digits.

The preferred provider network for FEP is Preferred Patient Care. FEP offers three nationwide options for federal employees and retirees (Standard Option, Basic Option and Blue Focus).

Additional information regarding FEP can be found at [http://fepblue.org](http://fepblue.org).

Providers participating in the PPC program are reimbursed based on the terms of their Agreement for services to FEP members and have agreed to accept the Florida Blue allowed amount (less deductible, coinsurance, and/or copayment) as payment-in-full for covered services. When FEP members access PPC providers, covered benefits are reimbursed at a higher benefit level and their coinsurance percentage is usually lower.

The FEP program reviews the reported room rate charges submitted on the Facility Charge Form by all participating hospitals. FEP will not allow any room and board charges greater than those reported on the Facility Charge Form to be included in the reimbursement calculation for those claims that are not reimbursed at the Diagnosis Related Group (DRG) allowance (inlier) or a calculation that uses the DRG allowance. Therefore, it is important to complete and submit the Facility Charge Form that is sent annually by Florida Blue.

The table(s) below provides information about FEP; the list is provided for your convenience and is subject to change.

<table>
<thead>
<tr>
<th>Product Name:</th>
<th>Network</th>
<th>How do members access physician and health care professionals?</th>
<th>Is specialist referral required?</th>
<th>Is the treating physician and/or facility required to give notice when providing certain services?</th>
</tr>
</thead>
</table>
| FEP Basic Option | Florida Blue- PPC | • FEP Basic Option members have open access to any PPC provider without designating a primary care physician.  
  • FEP Basic Option members must use PPC providers to receive benefits. The plan does not allow members to seek out-of-network services except under special emergent circumstances.  
  • Participating Traditional/PPS/PHS are considered out-of-network for PPC members. There is no balance billing protection for out-of-network services.  | No, referrals to specialists are not required. | Yes, on selected procedures and services, See guidelines in the [Utilization Management](#) section of this Manual. |
<table>
<thead>
<tr>
<th>Product Name:</th>
<th>Network</th>
<th>How do members access physician and health care professionals?</th>
<th>Is specialist referral required?</th>
<th>Is the treating physician and/or facility required to give notice when providing certain services?</th>
</tr>
</thead>
</table>
| FEP Standard Option | Florida Blue-PPC | ● FEP Standard Option members have open access to any PPC provider without designating a primary care physician.  
● FEP Standard Option members are allowed to seek out-of-network services from providers participating in the Traditional/PPS/PHS network.  
● Covered benefits may be reimbursed at a lower non-participating level. | No, referrals to specialists are not required. | Yes, on selected procedures and services. See guidelines in the Utilization Management section of this Manual. |
| FEP Blue Focus | Florida Blue-PPC | ● FEP Blue Focus members have open access to any PPC provider without designating a primary care physician.  
● FEP Blue Focus members must use PPC providers to receive benefits. The plan does not allow members to seek out-of-network services except under special emergent circumstances.  
● Participating Traditional/PPS/PHS are considered out-of-network for PPC members. There is no balance billing protection for out-of-network services. | No, referrals to specialists are not required. | Yes, on selected procedures and services. See guidelines in the Utilization Management section of this Manual. |
State Employee PPO

Alpha Prefix: XJJ

In-Network: Preferred Patient Care (PPC)

Out-of-Network: Members have balance billing protection when receiving services from providers who participate in the Payment for Professional Services (PPS)/Payment for Hospital Services (PHS)/Traditional network.

BCBSF is the servicing agent for the State Employees’ PPO Plan. The Plan provides coverage for State of Florida employees, retirees, surviving spouses and their eligible dependents. State Plan contract numbers on the member’s ID card begin with the alpha prefix “XJJ” followed by an “H” and eight digits.

In addition to the standard State Employees’ PPO Plan, BCBSF administers the State’s new Health Investor PPO plan. Members enrolled in the Health Investor PPO medical plan have lower premiums in exchange for higher deductibles and out-of-pocket limits.

The Health Investor PPO plan covers the same medical services and supplies as the standard State Employees’ PPO plan. However, with the exception of some routine physical exams and health screenings such as well-child care and adult preventive care, the deductible applies before any benefits are paid.

The preferred provider network for State Employees’ PPO Plan is PPC. Members may seek care from providers in their network, PPC, Traditional/PPS/PHS network providers, or non-network providers. BCBSF will make the payment directly to the provider for covered services.

The preferred provider network for State Employees’ PPO Plan is PPC. Members may seek care from providers in their network, PPC, Traditional/PPS/PHS network providers, or non-network providers. BCBSF will make the payment directly to the provider for covered services.

State Employees’ PPO Plan members also have access to the Traditional/PPS/PHS network. When members access Traditional/PPS/PHS providers, covered benefits are usually reimbursed at a lower level and their coinsurance percentage is higher. As a participating Traditional/PPS/PHS network provider, you may not balance bill the member.
Medicare Products

Florida Blue operates as a Medicare Advantage Organization and has members enrolled in both Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO) lines of business. Florida Blue Medicare Advantage products include BlueMedicare Select, BlueMedicare Choice, BlueMedicare Group PPO, and BlueMedicare HMO. BlueMedicare Group HMO, BlueMedicare Private Fee-For-Service (PFFS) and BlueMedicare Group PFFS products are no longer offered.

Note: A notification of a referral from a Primary Care Physician is now required for ALL BlueMedicare HMO products when the member requires treatment from specialists, including all ophthalmologists with the exception of dentists, mental health and substance abuse providers, podiatrists, dermatologists, dialysis, chiropractors, women’s health specialists for routine and preventive services, and urgent and emergency care providers.

As a MA Organization, we must comply with applicable federal and state statutes, regulations, and policies. In turn, a provider contracting to furnish services to Medicare Advantage members must comply with applicable federal and state statutes, regulations and requirements, and our policies and procedures.

When a Medicare beneficiary enrolls in a Medicare Advantage plan, it takes the place of Original Medicare benefits. Medicare Advantage members receive a document called the Medicare Advantage Evidence of Coverage (EOC). It explains the covered services and defines the rights and responsibilities of the member and Florida Blue.

For those services covered by the MA plans, MA members are responsible for copayments, and deductibles and coinsurance (if applicable) only. Medicare providers may not balance bill qualified Medicare beneficiaries for Medicare cost share amounts, for more information please see the October 2016 Bulletin on our Florida Blue site at www.bcbsfl.com. The ID card will indicate the product name (BlueMedicare HMO, BlueMedicare Select, BlueMedicare Choice and BlueMedicare Group PPO) and also display the words "Medicare Advantage PPO" or "Medicare Advantage HMO".

The BlueMedicare Preferred HMO network is contracted by Alignment Health Care. Please see their website at https://providers.ahcusa.com/ahc/default.asp to download a copy of the Provider Manual.
**MedAdvantage/BlueMedicare HMO/PPO Product**

This table provides information about Florida Blue Medicare Advantage products. This product list is provided for your convenience and is subject to change over time.

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Network(s)</th>
<th>How do members access physician and health care professionals?</th>
<th>Is a specialist referral required?</th>
<th>Are the treating physician and/or facility required to receive authorization when providing services?</th>
</tr>
</thead>
</table>
| BlueMedicare Group PPO | Medicare Advantage PPO (MAPPO)  
Medicare Advantage PPO (MAPPO)  
Network Sharing (out-of-state) | BlueMedicare Group PPO members have open access to any Med-Advantage PPO provider without designating a Physician of Choice. BlueMedicare Group PPO allows members to seek out-of-network services. Providers that do not accept Medicare assignment cannot bill member greater than 15% over the allowed amount, unless the provider has completely opted out of the Medicare program. | No, referrals to specialists are not required. | Yes, on selected procedures and services. See guidelines in the *Utilization Management* section of this Manual. |
<table>
<thead>
<tr>
<th>Product Name</th>
<th>Network(s)</th>
<th>How do members access physician and health care professionals?</th>
<th>Is a specialist referral required?</th>
<th>Are the treating physician and/or facility required to receive authorization when providing services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueMedicare Choice</td>
<td>Medicare Advantage PPO (MAPPO)</td>
<td>BlueMedicare Choice members have open access to any Medicare Advantage PPO provider without designating a Physician of Choice.</td>
<td>No, referrals to specialists are not required.</td>
<td>Yes, on selected procedures and services, See guidelines in the Utilization Management section of this Manual.</td>
</tr>
<tr>
<td></td>
<td>Medicare Advantage (MAPPO) Network Sharing (out-of-state)</td>
<td>BlueMedicare Choice allows members to seek out-of-network services. Providers that do not accept Medicare assignment cannot bill member greater than 15% over the allowed amount, unless the provider has completely opted out of the Medicare program.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Product Name</td>
<td>Network(s)</td>
<td>How do members access physician and health care professionals?</td>
<td>Is a specialist referral required?</td>
<td>Are the treating physician and/or facility required to receive authorization when providing services?</td>
</tr>
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<td>-----------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>BlueMedicare Select</td>
<td>Medicare Advantage (MA PPO)</td>
<td>BlueMedicare Select members have open access to any Medicare Advantage PPO provider without designating a primary care physician. BlueMedicare Select allows members to seek out-of-network services. Providers that do not accept Medicare assignment cannot bill member greater than 15% over the allowed amount, unless the provider has completely opted out of the Medicare program.</td>
<td>No, referrals to specialists are not required.</td>
<td>Yes, on selected procedures and services, See guidelines in the <strong>Utilization Management</strong> section of this Manual.</td>
</tr>
<tr>
<td></td>
<td>Medicare Advantage PPO (MA PPO)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Network Sharing (out-of-state)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BlueMedicare HMO</td>
<td>BlueMedicare HMO (MM) (Medicare Advantage MA HMO)</td>
<td>Members choose or are assigned a Primary Care Provider (PCP) from the network of participating physicians. Members are required to see their assigned PCP to coordinate their care. Only a Blue Medicare HMO member’s assigned or selected primary care physician can issue a referral. Providers must make sure this is done before services are provided to the member. You can verify if a referral is on file electronically through Availity® at availity.com. Blue Medicare HMO primary care physicians are responsible for issuing referrals to specialists. Primary care physicians who are</td>
<td>Yes, referrals to specialists are required.</td>
<td>Yes, on selected procedures and services, See guidelines in the <strong>Utilization Management</strong> section of this Manual.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
part of a multi-specialty group must issue a referral in order for a Medicare Advantage HMO member to visit a specialist within the same group.

Important: Blue Medicare HMO members must have a referral and/or authorization on file. If an authorization or referral is required and one is not on file, then the services may not be covered.

BlueMedicare HMO does not cover out-of-network benefits (except for emergency and urgent care, dialysis services, or services specifically authorized).
About National and Local Coverage Determinations for BlueMedicareSM Members

The Centers for Medicare & Medicaid Services (CMS) have established policies to determine whether a service is reasonable and necessary according to Medicare guidelines. For our Medicare Advantage members (BlueMedicareSM), we will apply guidelines established in National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) to determine medical necessity under these products. In the absence of policy in either of these sources, we may use criteria established in our medical policies or Medical Coverage Guidelines (MCG). These policies are in addition to any benefit limitations/exclusions as outlined in the member’s Evidence of Coverage (EOC). Additional guidance may also be found in the Medicare Claims Processing Manual or the Medicare Benefit Policy Manual found on www.cms.gov.

A National Coverage Determination (NCD) is a nationwide determination of whether Medicare will pay for an item or service. Medicare coverage is limited to items and services that are considered reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category).

In the absence of an NCD, an item or service may be covered at the discretion of Medicare contractors based on a Local Coverage Determination (LCD). Each “Select” or Choice Medicare contractor can establish which services are reasonable and necessary within its jurisdiction and, therefore, covered as a Medicare benefit.

Procedure and diagnosis codes are audited before Medicare Advantage claims are paid to ensure the service or treatment meets all Medicare Coverage Guidelines (MCG). If upon review, it is determined that the service does not meet Medicare NCD, LCD or MCG guidelines, the claim may be denied and the provider may not bill the member for the service.

Physicians and other providers are responsible for understanding whether specific items and services are covered under Original Medicare and, therefore, also covered by our Medicare Advantage plans. A member’s eligibility and benefits may be verified electronically through Availity® at Availity.com. If there is uncertainty regarding whether a particular service requested by a member is covered under Medicare, the provider or the member may request a pre-service “Organization Determination” from the plan. You may also request a pre-service “Organization Determination” for issues related to referrals.

If the pre-service Organization Determination is denied and the provider still renders the service, the claim must be billed using a -GA modifier (indicating a waiver of liability statement, known as an Integrated Denial Notice (IDN) for Medicare Advantage plans, was issued by the provider in advance, as required by plan guidelines).
The -GA modifier may only be billed if both an adverse Organization Determination was received and the member’s signature is on file in the provider’s record, indicating that the member was advised in advance of the service and clearly understands that it is not covered and that he/she has agreed to be responsible for the cost of the service. If the provider did not obtain the IDN in advance of providing a non-covered service, then the member may not be billed for that service.

We may not pay for the referred services if it is outside of our contractual agreements, and the provider would be responsible for the payment and is not allowed to bill the patient, except for the applicable cost-sharing for that service as set forth in the member’s EOC.

Also, under Medicare Advantage, unlike Original Medicare, providers are prohibited from using an Advance Beneficiary Notice (ABN). Instead, the pre-service “Organization Determination” process described above must be followed, and the IDN used in place of an ABN.

For more information regarding edits, policies or Organization Determinations, please refer to:

- The CMS Medicare Coverage Database for information about NCD and LCD guidelines applicable to services rendered in Florida. These guidelines can be found at www.cms.gov.


Medicare Advantage- Blue Medicare

Preventive Benefits

Medicare Advantage plans cover many preventive services for members. The goal of preventive care is to prevent disease and its consequences. Preventive care includes programs aimed at warding off illnesses (e.g., immunizations), early detection of diseases and inhibiting further deterioration of the body.

The following preventive care services are covered:

- Annual flu vaccine
- Colorectal cancer screening
- Annual fecal occult blood Barium enema (can be substituted for sigmoidoscopy or colonoscopy)
- Flexible sigmoidoscopy
- Screening colonoscopy once every two years for members with serious and complex medical condition(s)
- Hepatitis B vaccine for intermediate or high-risk beneficiaries
- Periodic health assessments by the member’s primary physician
- Pneumococcal vaccine
- Annual pap smear and clinical breast and pelvic examination
- Mammograms, screening and diagnostic (unlimited)
- Bone mass measurements
- Prostate cancer screening exam
- Diabetes monitoring, training and supplies (includes annual diabetic retinal eye exam, glucose monitors, test strips, lancets, and self-management training for members with diabetes)
- Abdominal aortic aneurysm screening
- Screening and behavioral counseling interventions during primary care to reduce alcohol misuse
- Screening for depression in adults
- Intensive behavioral therapy for cardiovascular disease
- Screening for sexually transmitted infections (STIs) and high-intensity behavioral counseling
- Annual Wellness Visits
- HIV Screening
- Intensive behavioral therapy for obesity
- Lung cancer screening
- Medical nutrition therapy
- Smoking and tobacco use cessation

Florida Blue and other Blue Cross and/or Blue Shield Plans, may provide available information concerning an individual’s status, eligibility for benefits, and/or level of benefits.

The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits.
BlueMedicare HMO members are permitted under their Medicare benefits to see the following kinds of participating specialists/providers for plan-covered services without first obtaining a referral:

- Dentists
- Mental health and substance abuse providers
- Podiatrists
- Dermatologists
- Dialysis
- Chiropractors
- Gynecologists for women’s routine and preventive health services
- Providers of most Medicare-covered preventive care (i.e., annual physical exam, colorectal screening, etc.)
- Urgent and emergency care providers
- Routine eye exams, diabetic retinal exams and glasses do not require a referral

**Emergency Care**

BlueMedicare HMO, BlueMedicare Select and BlueMedicare Group PPO cover emergency services worldwide. Members are encouraged, when possible, to contact and visit their PCP or participating physician when they require medical care. If the physician cannot see the member, the member should be directed to a Medicare Advantage network facility or, when appropriate, to the nearest facility. A member is not required to contact a participating physician prior to receiving emergency services and an authorization is not required, whether in or out of the service area. However, an authorization is required for BlueMedicare HMO and a notification is required for BlueMedicare Select in the event the emergency services result in an inpatient admission.

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency care is covered for inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services, and
- Needed to treat, evaluate or stabilize an emergency medical condition.
Medicare Supplement Products - Advantage 65

In addition to Medicare Advantage plans, Florida Blue offers Medicare beneficiaries age 65 and over, as well as beneficiaries under 65 with disabilities, a number of Medicare Supplement insurance policies.

Medicare Supplement policies are purchased in addition to traditional Medicare and cover the 20% benefit that traditional Medicare DOES NOT cover. Medicare Supplement policies will ONLY cover services traditional Medicare covers.

- Members enrolled in our “traditional” Medicare Supplement plans have the freedom and flexibility to choose any hospital or physician for their health care services (there are no network limitations).
- Members enrolled in our “Select” plans must choose from physicians and/or hospitals that participate in our Select networks.
- There are several choices of Select plans. The type of Select plan is indicated in the upper right hand corner on the front of the ID card.

Blue Medicare Premier HMO

The new BlueMedicare Premier HMO, effective 1/1/2017, is a narrow network product offered in key areas of the state. The product will have a new limited Primary Care Provider (PCP) network that will utilize providers who participate in risk arrangements to improve patient outcomes.

To support the new BlueMedicare Premier HMO product, there will be a new PCP network built in Broward, Miami-Dade and Orange counties. The new narrow PCP network will utilize the existing BlueMedicare HMO Specialists, Hospitals and Ancillary Networks which are contracted through the Health Options, Inc. (HOI) agreement. The PCP network will be comprised of a few providers and physician entities (MSO, IPAs, and Staff Model Practices) experienced in managing a Medicare population, and will assume full Part A, B and D financial risk for their assigned population. See the Medicare ID Card Section, page 48, for an example of the member ID card.

The PCPs and physician entities will include some Florida Blue existing Collaborative Care Model and Full Risk partners (e.g., Inter-American Medical Centers (IMC) and Baptist Health South Florida (BHSF) as well as new partners). The product will have PCP assignment and referrals for specialist/facility services will be managed by the PCP. BlueMedicare Premier HMO is contracted so that although the group is par with the network, only select PCPs within the group will be considered participating in this product.

Important things to remember:

- Only those PCPs that are contracted as participating within the group will be displayed on the Online Provider Directory (OPD)
- Only those PCPs that are contracted as participating within the group will be allowed for PCP selection or PCP assignment
- Non-participating PCPs within the group, will be allowed to cover for participating PCPs
- All claims from non-participating PCPs within the group will be paid according to the participating PCP payment arrangement.
Global Plans for Group Business

Blue Cross Blue Shield Global™ solutions provide a best-in-class, comprehensive suite of international solutions for people who live, work and travel internationally. Through Blue Cross Blue Shield Global, members can have the confidence that quality care can be accessed wherever and whenever needed. These solutions are available through Florida Blue and GeoBlue, an independent licensee of the Blue Cross and Blue Shield Association.

Blue Cross Blue Shield Global Solutions cover the needs of U.S. based companies and their mobile employees across the globe for short trips and long-term assignments, giving them the power of Blue, with access to the strongest healthcare network in the U.S. combined with GeoBlue’s hand-picked, elite international network – all supported by high-tech, high-touch service.

**BCBS Global Expat** – A guaranteed issue, group plan that combines comprehensive global benefits with medical assistance services. This plan is designed for international assignees and their families when they leave their home country for six months or more.

- Full-featured, internationally focused wellness program
- Global coverage with no excluded countries
- Rich and flexible benefits that cover everything from medical evacuation and hospitalization to chronic and maternity care
- Available to groups of two or more employees

**BCBS Global Traveler** – A short term, group plan that provides supplemental medical benefits and services for international business travelers.

- Blanket coverage that provides easy administration
- Rich benefits offering 100% coverage with no deductible for any accident or illness, including hospitalization and medical evacuation
- Employees are covered when they are outside their home country for trips lasting up to 180 days.
- Additional riders available – spouse/dependent coverage, sojourn travel coverage, AD&D, and political security & natural disaster evacuation
Individual Canadian Travel Insurance

**Alpha Prefix:** Not applicable  
**In-Network:** Preferred Patient Care (PPC)  
**Out-of-Network:** There are no out-of-network benefits. Upon exception and authorization, a member may be able seek services from a PPS/PHS/Traditional provider.

Providers participating in PPC are reimbursed based on the terms of their Agreement for services to Canadian Travel Insurance members and have agreed to accept the Florida Blue allowed amount as payment-in-full for covered services.

**Benefit Information**

- Atlantic and Ontario Policies:  
  - Only covers services resulting from an accident, medical emergency or sudden illness.  
  - Deductible and copays do not apply.

- Quebec Policies:  
  - Only covers services resulting from an accident or sudden illness.  
  - Deductible and copays do not apply

**Utilization Management for Canadian Travel Insurance**

Call Canadian assistance for pre-approval of all medical services.

Include the following on the CMS-1500 or UB-04 claim form:

- the member's health insurance number in block 1a (CMS-1500) or field 60 (UB-04)  
- the insurance policy number in block 11(CMS-1500) or field 62 (UB-04)  
- the authorization number provided by Canassistance
HEALTH CARE IDENTIFICATION CARDS

We offer a variety of product lines to meet the health care coverage needs of our members. Just like a credit card, the member’s ID card can be swiped through a card reader to access real-time eligibility and benefit information via Availity that also provides access to CareCalc, Availity Care Profile and other online capabilities (see the Self-Service Tools Frequently Referenced Section for additional information).

Further, presentation of our ID cards in no way creates, nor serves to verify an individual’s status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits.

ID Cards

BlueCare - HMO

BlueChoice – Preferred Patient Care
CompCoverage (A, B, C, D, F)

<table>
<thead>
<tr>
<th>BlueCross BlueShield of Florida</th>
<th>Benefit Highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td>CompCoverage Plan</td>
<td>Part A Hospital Deductible Covered</td>
</tr>
<tr>
<td></td>
<td>Part A and B Coinsurance Covered</td>
</tr>
<tr>
<td>HERBERT F. 6SA</td>
<td>Part B Annual Deductible Not Covered</td>
</tr>
<tr>
<td>Contract No. SH11111111</td>
<td></td>
</tr>
<tr>
<td>Group No. BC Plan 99999 6SA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Customer Service No. 1-800-926-6565</td>
<td></td>
</tr>
<tr>
<td>An Independent Licensee of the Blue Cross and Blue Shield Association</td>
<td></td>
</tr>
</tbody>
</table>

Traditional (PPS/PHS)

<table>
<thead>
<tr>
<th>BlueCross BlueShield of Florida</th>
<th>Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>THOMAS A. TESTNAME8</td>
<td>HOW CAN BLUE HELP YOU?</td>
</tr>
<tr>
<td>Member Number XJWH88888888</td>
<td>Notice to Participating Provider: Collect for coinsurance, copays, deductibles, and all other covered services only the amount your member has been reimbursed. The difference between your charge and our reimbursement is your member's responsibility. The member is responsible for paying the difference between their charge and our allowance. When submitting claims and/or inquiries, always include the name and complete member number including the alpha prefix, as shown on the front of the card.</td>
</tr>
<tr>
<td></td>
<td>Florida Provider Service Center: P.O. Box 1786, Jacksonville, FL 32231</td>
</tr>
<tr>
<td></td>
<td>Possession of this card does not guarantee eligibility for benefits. To locate participating provider outside of Florida, call the number above or visit <a href="http://www.bcbs.com">www.bcbs.com</a>.</td>
</tr>
</tbody>
</table>

State Employee ID

<table>
<thead>
<tr>
<th>Florida Blue</th>
<th>Preferred Patient Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUTH A. FIELD</td>
<td>Member Number XJWH12345678</td>
</tr>
<tr>
<td>BC 090 BS 590</td>
<td>PPO Group number 76442</td>
</tr>
<tr>
<td>State Employees Group</td>
<td>A Self Insured Plan</td>
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</tbody>
</table>

Florida Blue Preferred Patient Care
<table>
<thead>
<tr>
<th>Member Name</th>
<th>I M Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID</td>
<td>R99919999</td>
</tr>
<tr>
<td>Enrollment Code</td>
<td>104</td>
</tr>
<tr>
<td>Effective Date</td>
<td>01/01/2008</td>
</tr>
<tr>
<td>RxPN</td>
<td>610239</td>
</tr>
<tr>
<td>RxGrp</td>
<td>650006500</td>
</tr>
</tbody>
</table>

**Federal Employee Program (FEP) ID**
Medicare ID Cards

Our Medicare Advantage and Medicare Supplement members receive a health care ID card designed to help you access our automated phone or online systems to verify benefits, eligibility and claim status. Each health care ID card includes a unique identifier that designates the Medicare Advantage or Medicare Supplement benefit plans.

Medicare Supplement-Advantage 65 ID Cards

BlueMedicare Supplement
### BlueMedicare Premier Rx ID Cards

<table>
<thead>
<tr>
<th>Member Name</th>
<th>RxBIN</th>
<th></th>
<th>RxPCN</th>
<th></th>
<th>RxGrp</th>
<th>Issuer</th>
<th>Group Number</th>
<th>Printed Date</th>
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<tr>
<td>J J Test</td>
<td>012833</td>
<td></td>
<td>MedPPrime</td>
<td></td>
<td>55904</td>
<td>80640</td>
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<td>MMDDYYYY</td>
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### BlueMedicare Complete Rx ID Cards

<table>
<thead>
<tr>
<th>Member Name</th>
<th>RxBIN</th>
<th></th>
<th>RxPCN</th>
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<th>RxGrp</th>
<th>Issuer</th>
<th>Group Number</th>
<th>Printed Date</th>
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<tbody>
<tr>
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### BlueMedicare Value Rx ID Cards

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BlueMedicare Select ID Cards

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BlueMedicare Value ID Card

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BlueMedicare Choice ID Card

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Florida Blue provides Medicare Advantage plans.
BlueMedicare Classic HMO ID Card

BlueMedicare Classic Plus HMO ID Card
BlueMedicare Preferred HMO ID Card

BlueMedicare Premier HMO

Florida Blue

BlueMedicare

Preferred (HMO)

Medicare Advantage

Member Name
J J Test

Primary Care Provider:
Dr. First Name M. Last Name

RxBIN 012833
RxPCN MedPrime
RxGrp H2758

Member Number XJCH45678910
Group Number 9999616001
Printed Date MMDDYYYY

Florida Blue

BlueMedicare

Premier (HMO)

Medicare Advantage

Member Name
J J Test

Primary Care Provider:
Dr. First Name M. Last Name

RxBIN 012833
RxPCN MedPrime
RxGrp H1026

Member Number XJIH45678910
Group Number 9999616401
Printed Date MMDDYYYY

47

Not a BlueCard/BlueShield service

Member Services 1-800-783-5880
Member Services TTY 1-888-255-8779
Pharmacy Member Services 1-855-457-0010
Provider Services 24/7 Nonmember DR
Rx Help Desk 1-800-963-8051
Enroll Services* 1-888-223-4002
Voice Services* 1-855-560-1855

Health Claims PO Box 10910 Orange, CA 92863
Rx Claims PO Box 28970 Lehigh Valley, PA 18022-0970

HMO coverage is offered by Brookshire Florida, Inc. DBA Florida Blue Preferred HMO, an HMO affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are independent Licensees of the Blue Cross and Blue Shield Association.
Utilization Management Programs

We have established various medical management (utilization management) programs for the review of service requests to determine benefit coverage provided under our policies. The medical management programs are a collaborative effort between us, providers and physicians to provide members with information that will help them make more informed decisions about their health care and coverage.

Clinical decision support criteria are used throughout the medical management process to determine whether or not a requested service qualifies for coverage under the member’s contract. The application of the definition of medical necessity (as defined in the member’s benefit plan or Evidence of Coverage) is solely for the purpose of determination of coverage or payment for services rendered by providers.

All services must meet the definition of medical necessity as outlined in the member’s benefit contract. Although a service may not require authorization, it is still required to meet the definition of medical necessity and is subject to medical necessity review pre-service, post-service or concurrently.

Per your Agreement with Florida Blue you are required to comply fully with medical management programs administered by Florida Blue.
This includes:

- Obtaining authorizations, certifications or notifications, depending upon the requirements of the member agreement in question.
- Providing clinical information which support medical necessity when requested.
- Identifying a contact person in the facility’s medical management department who will provide the member’s medical information to the Florida Blue medical management onsite or telephonic nurse reviewer.
- Permitting access to the member's medical information.
- Including the Florida Blue medical management nurse in discharge planning discussions and meetings.
- Providing a plan of treatment, progress notes, and other clinical documentation as required.

Providing quality service to your patients, our members, while following utilization management guidelines can be a time consuming part of your day; our goal is to ease this process by providing useful details in this section of the manual.

Florida members who are currently enrolled or any new member enrolled in a Florida Blue Individual Qualified Health Plan (QHP) or Small Group Qualified Health Plan (QHP) will be required to ensure prior authorization is obtained for advanced imaging, specialty medical pharmacy and sleep studies. Please login to Availity® or contact Florida Blue at 1-800-727-2227 when a member checks in to verify if prior authorization is required.

**Note:** For products that require a referral from the member’s PCP (myBlue and Medicare Advantage HMO), the referral is required for a specialist to order or render any of these services, excluding the following specialists – OB&GYN, Chiropractic, Podiatrists, Behavioral Health and Dermatologists.

For more details including services requiring Utilization Management please see our [Frequently Referenced Utilization Management Section](#).
Medical Policies, Medical Coverage Guidelines (MCG)

We process claims based on the member’s eligibility, benefits, and the medical necessity of the service provided. Evidence-based Medical Policies (Medical Coverage Guidelines) are used to help determine coverage under the medical necessity provisions of member contracts and Certificates of Coverage. In developing its Medical Policies (Medical Coverage Guidelines), we look to current best available external clinical evidence, specialty societies, physician consultants, the Food and Drug Administration FDA, and the BCBSA.

Note: CMS establishes its own medical guidelines mandated by law for Medicare beneficiaries. Although the criteria for reviewing services may be similar, the Medicare medical guidelines and our Medical Policies (Medical Coverage Guidelines) are not interchangeable.

Medical Policies (Medical Coverage Guidelines) are available on the Florida Blue website. Look for notification of periodic updates in the “What's New” section of the Medical Policies (Medical Coverage Guidelines). They can also be obtained through Availity; when receiving Eligibility & Benefits summary results, you can click on the Coverage Guidelines link located at the bottom of the screen. For providers participating in the CareCentrix network, please note, CareCentrix follows published Medical Policies (Medical Coverage Guidelines).

Certificates of Medical Necessity (CMN)

To expedite the medical review process for certain requests, we provide Certificate of Medical Necessity (CMN) forms to our Providers. Each CMN is associated with one of our Medical Coverage Guidelines (MCG). CMNs offer Providers a way to attest to information within a member’s medical documentation, rather than requiring the Provider to send that documentation to us.

Additionally, a blue document symbol will appear in the top left corner of each associated MCG following the 9-digit MCG policy number. This indicates an MCG has an associated CMN. Information about each CMN is located in the Position Statement section in each MCG.

Pre-Service Medical Review Fax Cover Sheet
Authorization Guidelines

An authorization is defined as an approval of medical services by an insurance company, usually prior to services being rendered.

Failure to obtain a prior authorization for the procedures listed in the appendixes will result in the member and/or provider being held financially responsible for the procedure.

Note: Members should be referred to a participating provider to maximize benefits and to avoid higher out-of-pocket expenses.

Referral Guidelines

A referral is defined as the process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency. For Florida Blue HMO members, referrals for most specialists must be obtained from the member’s Primary Care Physician (PCP) to a participating specialist and / or ancillary location (i.e. Rehab, and Free-Standing Facilities).

BlueMedicare HMO members in South Florida counties (Broward, Martin, Miami-Dade, Palm Beach, and St. Lucie) who require ophthalmology services must be referred to Eye Management Inc. (EMI).

Note: For products that require a referral from the member’s PCP (myBlue and Medicare Advantage HMO), the referral is required for a specialist to order or render any of these services, excluding the following specialists – OB&GYN, Chiropractic, Podiatrists, Behavioral Health and Dermatologists.
Pharmacy Utilization Management Guidelines

Select prescription drugs, including injectable medications, may require that specific clinical criteria are met before the drugs will be covered under Florida Blue's pharmacy and/or medical benefit programs.

**Note**: Always verify member’s benefit as some utilize an exclusive provider organization (EPO) for pharmacy benefits and the pharmacy has to be a participating pharmacy in order to receive coverage. Benefits vary according to the terms of the member contract. Verify benefits prior to rendering services.

Reference the [2016 Medical Pharmacy Drug List](#) for a list of drugs requiring prior approval. If the drug is listed and you are an in-network participating provider please reference the [Provider Administered Drug Program](#) (PADP) for a list of drugs managed by Magellan RX Management. If the drug is managed by Magellan RX Management please contact Magellan RX Management.

If the drug is not listed in PADP or you are not a participating provider please contact Florida Blue at 1-800-727-2227.

For FEP Basic, Standard and Blue Focus products - Prior approval required for certain medications; please refer to Caremark for a current Rx drug prior approval list.

**Provider Administered Drug Program (PADP) Guidelines**

Florida Blue contracted with Magellan RX Management to assist in managing the PADP. The program is designed to maximize patient care in the most appropriate and affordable manner based on clinically accepted standards. Depending upon the member’s benefits it is important to note that drugs not covered under PADP may require prior authorization through Florida Blue. Authorizations can be obtained through Availity.

The program is not applicable for drugs administered in an emergency room, observation unit or during an inpatient stay. Additionally, this program is not applicable for drugs ordered through Florida Blue Specialty Pharmacy Program (i.e. ‘Just in Time’, ‘Drug Replacement’).

As with all utilization management programs, PADP will be utilized to determine if the proposed service meets the definition of medical necessity under the member’s benefit plan. Additions to this list will be made periodically in accordance with applicable provisions of your contract(s). Additionally, certain member benefit agreements may require prior authorization for certain drugs.

For physicians who supply and bill and participate in the PADP program a pre-service review is required prior to the administration of certain specified drugs in the following settings: office, home, outpatient hospital, ambulatory surgical center, public health clinic and rural health clinic. If pre-service review is not obtained for the applicable drug, payment for that service will be denied. Members cannot be held responsible for denied charges.
Effective November 14, 2016, Florida Blue will expand the Physician-Administered Drug Program (PADP) managed by Magellan Rx Management and will now require preservice reviews for the drug on the PADP list when the administration of the drug in the office, home, outpatient hospital, ambulatory surgical center, public health clinic, and rural health clinic settings. If you administer any of the drugs on the PADP list on or after November 14, 2016 without requesting a preservice review, the claim will deny and you may not bill the member for the denied charges.

Magellan Rx Management

Specialty Medications

Certain medications, such as injectable, oral, inhaled, and infused therapies used to treat complex medical conditions are typically more difficult to maintain, administer, and monitor when compared to traditional drugs. Specialty medications may require frequent dosage adjustments, special storage and handling, and may not be readily available at local pharmacies or routinely stocked by physicians’ offices, mostly due to the high cost and complex handling required. Use of the Specialty Pharmacy to provide specialty medications results in significant cost savings, which lowers the amount members have to pay for these medications.

Order self-administered specialty medications from the preferred specialty pharmacy supplier noted in the Medication Guides. Refer to the Medication Guides for a complete list of medications and to verify which specialty medications require prior authorization. If prior authorization is required, refer to the program steps above.

When a covered specialty medication is administered in the physician’s office, two options for obtaining the medication are available:

1. Order the injectable medication from the specialty pharmacy supplier noted in the Medication Guide. The specialty supplier can provide specialty medications for in-office administration, using one of two service options:
   - **Just in time service** – Medications should be ordered one to two weeks in advance of the service date to allow for eligibility/coverage review and shipping.
   - **Stock replacement service** – Medication order should be submitted within 30-days of the service date that the medication was administered in your office.

The specialty supplier will contact the provider’s office staff to confirm medication delivery. Do not file a claim to Florida Blue for the specialty medication; instead, the specialty pharmacy will bill Florida Blue directly. The provider should continue to bill applicable office visit procedure codes including medication administration codes, as is customary and in accordance with standard billing practices. Collect the office visit cost share (copayment, deductible, and/or coinsurance if applicable) as applicable per the member’s benefit agreement.
2. Provide the medication from your own supply

In this instance, the physician should file a claim directly to Florida Blue for reimbursement of the medication (“buy and bill”). Member responsibility is based on the member’s benefit agreement. The provider should continue to bill applicable office visit procedure codes including medication administration codes, as is customary and in accordance with standard billing practices. Collect the office visit cost share (copayment, deductible, and/or coinsurance if applicable) as applicable per the member’s benefit agreement.

Note - Refer to Specialty Pharmacy Remote Provider Guidelines in our Utilization Management Frequently Accessed Section

Voluntary Predetermination for Select Services (VPSS) Guidelines

VPSS is a voluntary pre-service medical necessity review for select procedures/services with an applicable medical policy guideline for non-HMO products. Although non-HMO products do not require authorizations, they may be subject to post service medical necessity review. However, if the VPSS program is used to review a procedure/service, it will typically eliminate the post service review for medical necessity of that procedure/service.

- A pre-service medical necessity review will not be conducted for the following reasons:
  - If there is no current medical policy published for the requested procedure/services at the time of the request. To determine if there is an applicable medical policy, refer to the Medical Coverage Guidelines (MCGs) on our website at FloridaBlue.com.
  - Non-covered services per the member’s benefit plan (check Availity for Member benefits)
  - To determine billing edits and/or inclusive or bundled services.
  - Secondary or Medicare Supplement members

- For Federal Employee Program (FEP), State Group and Medicare Advantage products, Florida Blue will continue to conduct a pre-service medical review regardless of the reasons stated above. Pre-service medical necessity reviews for these members are determined at the time services are rendered according to the terms of the member contract.

Note: Per the FEP contract, FEP members do not have pre-service appeal rights. For additional information, please review Utilization Management by Product/Network for FEP.

- Members will have appeal rights in the event of a pre-service adverse benefit determination:
  - A member, or provider on behalf of a member, has the right to a pre-service appeal. To submit an appeal on a member’s behalf, complete the PPO/Non-HMO Member Appeal form and obtain written permission from the member by completing the Member Appeals Appointment of Representation Form and submit the forms to Florida Blue. Both forms can be accessed from the member website at FloridaBlue.com.

The member is financially responsible for any rendered service deemed not medically necessary as a result of the VPSS review process.
Florida Blue reserves the right to perform audits to assure all previous information submitted is accurate. Florida Blue will not typically conduct a post service medical necessity review for any services previously reviewed through VPSS. Claims will process according to the coverage terms, limitations and exclusions of the member’s benefit plan at the time services are rendered. It is important to recognize, however, that the final determination of whether or not a procedure is covered will depend on the actual claim(s) submitted and the services performed.

How To

Please fax your request for voluntary review. On your cover sheet, please indicate that you are requesting a voluntary review. Please include supporting documents or a Certificate of Medical Necessity.

Include your contact information in case the reviewer needs additional information.

- When requesting a review, fax your request per the instructions below:

<table>
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<tr>
<th>Plan Type</th>
<th>Note on Cover Sheet</th>
<th>Fax Number</th>
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<tr>
<td>Federal Employee Program (FEP)</td>
<td>Requesting VPSS</td>
<td>(877) 219-9448</td>
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<tr>
<td>State Employees’ PPO Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Advantage (Blue Medicare) PPO</td>
<td>Requesting Organizational Determination</td>
<td>(904) 301-1614</td>
</tr>
<tr>
<td>For all other Lines of Business such as Blue Options (Network Blue), Blue Select or Blue Choice (Preferred Patient Care) Exceptions: FEP, State Group, Medicare Advantage (Blue Medicare) HMO or PPO</td>
<td>Requesting VPSS</td>
<td>(877) 219-9448</td>
</tr>
</tbody>
</table>

Note: You can also check the status of your request electronically through Availity®
CLAIMS PROCESS

This section of the Manual for Physicians and Providers explains certain aspects of the claim process. For a more in-depth outline, please refer to our Frequently Referenced Billing Section.

See Payment Policies on Florida Blue’s website for information on payment methodologies, payment rules, and how Florida Blue applies those rules to your claim.

Site of Service

Based on the CMS methodology, Florida Blue will reimburse specific CPT/HCPCS codes based on the site of service where the service is performed. This differential recognizes that physician practice costs are generally lower when services are provided in a facility location. This approach has been used by Medicare for several years and is consistent with standard practices in the health care industry. To determine which services and locations are reimbursed at the facility rate, Florida Blue uses the same criteria that are applied by Medicare. To identify the services for which a Site of Service differential applies, you can consult the CMS website or use the Fee Schedule Request Form on Florida Blue’s website.

Substitute Physicians

A substitute physician, sometimes called a locum tenens physician, is a physician who is hired to temporarily replace another physician ("usual" physician). The usual physician may be absent for reasons such as illness, pregnancy, vacation or continuing medical education. This absence should not exceed 60-days unless the usual physician has been called to active duty in the Armed Forces. The usual physician bills and receives payment for the substitute (locum tenens) physician’s services as though the usual physician performed the services. The usual physician is responsible for reimbursing the substitute (locum tenens) physician for services rendered and ensures that the substitute (locum tenens) physician shall not bill or seek payment from the member. The usual physician identifies the reported services as locum tenens physician services by entering code modifier Q6 (service furnished by a locum tenens physician) after the procedure code on the CMS-1500 claim form.

Advanced Non-Physician Practitioners

Physician Extender services should be billed with the extender’s NPI or Florida Blue number in block 24J on the CMS-1500 as the rendering provider.

Florida Blue requires a separate claim for each rendering provider. A single service rendered by two or more providers for the same member on the same date of service must be billed with the provider who performed the substantive portion of the service in block 24J. Illustrative examples are listed below:

- If the Physician Extender performs the history and physical and the physician evaluates the patient’s medical condition, orders tests, and develops a treatment plan, then the service should be billed with the physician as the rendering provider.
- If the Physician Extender performs the history and physical, evaluates the patient’s medical condition, orders tests, and develops the treatment plan and the physician enters the examination room to confirm the diagnosis and treatment plan, then the service should be billed with the Physician Extender as the rendering provider.
Physician Extenders
Physician Extenders should not submit claims under the following circumstances:

- Services were not personally performed. The supervision of other staff does not constitute a personally performed professional service.
- A facility, hospital, or birthing center is paid an allowance for the extender’s professional services.

Claims submitted are an attestation of services performed. Florida Blue reserves the right to conduct audits and/or reviews to ensure claims are submitted appropriately.

Where contractual language allows, covered services rendered by physician extenders not directly contracted with Florida Blue will be reimbursed at 85 percent of the contracted provider’s rate where a RVU exists. Physician Extenders directly contracted with Florida Blue will be reimbursed at the contracted rate.

Surgical first assist services by a licensed physician extender should be billed by the employing physician, group, employer or clinic with the addition of modifier AS and the physician extender NPI or Florida Blue provider number entered in block 24J as the rendering provider. Florida Blue will reimburse these services at 20 percent of the allowed amount when the service is covered and the surgery warrants a surgical assistant. Effective January 1, 2011, BCBSF will reimburse these services at 16 percent of the allowed amount when the service is covered and the surgery warrants a surgical assistant.

Types of Claim Submissions

Paper Claims

Instructions for completing the CMS-1500 and UB-04 claim forms can be obtained from the following websites:

- Florida Hospital Association [www.fha.org](http://www.fha.org)
- National Uniform Billing Committee [www.nubc.org](http://www.nubc.org)
- National Uniform Claim Committee [www.nucc.org](http://www.nucc.org)
- FL Blue Electronic Transaction Companion Documents
Electronic Claims

Electronic Claim Submissions allow providers to safely submit and track HIPAA-compliant electronic claims to us via Availity without manual intervention.

Electronic claims must be filed through Availity or send your claims through a billing service or clearinghouse to transmit to Availity and then route to us. Availity edits transactions according to the HIPAA-AS requirements. A number of payer specific edits are also performed before routing transactions to Florida Blue.

If a claim transaction fails either the HIPAA-AS or our edits, Availity will not forward the claim to us for payment. Provider receives standard messaging on their Availity electronic batch report (EBR) and can review it before resubmitting claims.

Note: Allow 30-days for receiving payment from Medicare and the Blue Plan before you resubmit Medicare Supplement claims. Accurate and complete claims, which include National Provider Identifiers, cross over to our system after Medicare processes them. Medicare releases the claim to the Blue Plan secondary payer for processing when they send your Medicare remittance notice.

Visit our Self Service Frequently Referenced Section for additional electronic transmission support information.

Prompt Claims Processing/Timely Filing Limits

Providers must file claims within the time set forth in their Florida Blue participating provider Agreement(s) unless applicable law requires a greater time period for filing of claims. If applicable to a particular benefit agreement, current Florida law and other legal requirements provide that claims must be filed within 180 days after the date of service and receipt by the provider of the name and address of a patient’s health insurer.

Provider should submit claims indicating their usual fees for services rendered. Florida Blue will make appropriate adjustments based on the contractual agreement.

Florida Blue complies with applicable legislation regarding timeliness of filing and processing claims.

Claim and Encounter Data Submissions

A critical element in claims filing is the submission of current and accurate codes to reflect the services provided. For proper payment and application of deductibles and coinsurance, it is important to accurately code all diagnoses and services in accordance with national coding guidelines.

Inclusion of a complete and accurate list of diagnosis codes associated with the member at the time of the encounter, including any chronic conditions not necessarily treated at the time of the encounter, will help ensure correct coding of the encounter. Additionally, it helps us match patients with appropriate care and disease management programs, and ensure members are properly classified by risk programs. We encourage you to purchase current copies of CPT, HCPCS, and ICD-9-CM code books.
It is particularly important to accurately code your claim because the level of coverage may very under the member’s benefit plan for different services. You must submit a claim and/or encounter, regardless of whether you have collected the member’s copayment, deductible or coinsurance at the time of service.

To prevent claims processing and payment delays, follow the claims filing hints below:

- Verify coverage. Groups often have changes in their health insurance benefit plans. Make re-verifying coverage through Availity, see our Frequently Referenced Self Service Section for more information.
- Submit the entire member ID number including alpha prefix. Submit the member ID number not the member’s Social Security number. Remember to correct your billing system when there are changes. The 835 electronic remittance advices will indicate when a member’s identification (ID) number is processed with a different identifier than was submitted.
- Complete all claim entry fields. To receive proper reimbursement, the claim information must be completed in its entirety. Incomplete or inaccurate information will result in a claim denial.
- Enter the date of onset, if applicable. All ICD diagnosis codes in the 800-900 range require a date of onset (injury, accident, first symptom, etc.).
- Use valid codes. CPT, HCPCS, and ICD codes are updated quarterly. Make sure you or your billing service is using the most up-to-date codes.
- Report an unlisted code only if unable to find a procedure code that closely relates to or accurately describes the service performed. Unlisted codes require documentation and therefore cannot be submitted electronically.
- Use diagnosis codes that indicate a general medical exam when billing for “preventive” health screening exams. Claims for these services will be denied if other diagnosis codes are used.
- Submit modifiers affecting reimbursement in the first and second position on claims. A procedure code modifier, when applicable, provides important additional information about the service performed. When multiple modifiers are necessary for a single claim line, modifiers should be submitted in the order that they affect payment.
- Submit multiple procedures on one claim. All procedures performed on the same date of service, by the same provider for the same patient should be submitted on one claim.
- Submit all applicable diagnosis codes. Code to the highest level of specificity possible. Most 3-digit codes require a fourth or fifth digit.
- Include the National Provider Identifier (NPI) for rendering physician and billing physician or group. Both the CMS-1500 and UB-04 include fields for the NPI.
CMS-1500:

- Block 24J is for Type 1 NPIs (Rendering Physician)
- Block 32A is for Type 2 NPIs (Service Facility)
- Block 33 A is for Type 1 or 2 NPIs (Billing Physician/Group)

The above blocks are split to allow your Florida Blue provider number in the shaded area and your NPI in the non-shaded area labeled NPI.

UB-04:

- Field 56 is for the NPI of the Billing Facility/Provider
- Field 76 is for Type 1 NPIs (Attending Provider)
- Field 78 and 79 are for Type 1 NPIs (Other referring provider)
- Use the correct Tax ID or Social Security number. For participating providers, the Tax ID Number (TIN) reported on the claim should match the TIN found within the provider agreement, which is the provider/legal entity's payee TIN. Should your legal entity TIN change, please contact your Florida Blue Network Manager directly before claims are submitted containing this new information
- When services are rendered in a facility that is NOT associated with the billing entity, enter name and address along with NPI if available.
  - Valid 9-digit zip codes are required.
- Submit the correct billing provider information.
  - Individual Physicians/Providers: Enter the name, address, phone number, and NPI of the individual physician, if services were rendered in a solo practice.
  - Groups: Enter the name, address, phone number and NPI of the group practice
  - Valid 9-digit zip codes are required.

Note: Billing provider address is the location where services were rendered and MUST be a street address. For electronic submissions, if the payment address is different than the billing address, submit in the “Pay To” including any P.O. Box.

- Avoid sending duplicate claims. For claims status, use Availity or contact Florida Blue. If filing electronically, be sure to also check your Availity file acknowledgement and EBR for claim level failures. Allow 15-days for electronic claims and 30-days for paper claims before resubmitting.
- Corrected claims. If you do not submit your corrected claims electronically, then indicate “Additional Services” on claims when billing for additions to the original claim. This will clearly distinguish your claim as being filed in addition to the original, but not replacing the original claim (i.e., a corrected claim). The additional services must be submitted on a paper claim form.
- Taxonomy Code. Claims should contain the proper provider taxonomy code, especially for MA members.
• NPI and Sub-part Identifiers. Claims should also contain the proper NPI for sub-units of a hospital, if applicable, especially for MA members or if the sub-unit is a participating with Florida Blue. If a NPI was not obtained for sub-units of the hospital, ensure the proper taxonomy code is used when billing Florida Blue.

You can learn more about the many tools available to help you prepare, submit and manage your Florida Blue claims at by accessing the Self-Service Tool Guide.

**Note:** To order CMS-1500 (formerly HCFA-1500) and CMS-1450 (also known as UB-04) forms, contact the U.S. Government Printing Office at (202) 512-0455, or visit their website at cms.hhs.gov.

**Medical Records**

Under certain circumstances, Florida Blue will suspend claims for medical review under an applicable medical or drug policy or for pre-existing in order to determine if the services rendered are covered. Clinical information/medical records for these select procedures/services may be requested to support claims adjudication. Failure to submit the clinical information/medical records may result in processing and payment delays.

Clinical documentation/medical records that maybe requested include, but are not limited to the following:

• History and physical
• Operative reports
• Physician/nurse notes
• Consultation reports
• Lab reports
• Radiology reports
• Anesthesia notes and time
• Physician orders
• Plan of treatment
• Medication name, physician order, dosage, units and NDC number
Requesting Medical Records

When additional documentation is required to process a claim, Florida Blue will fax or mail a written request to you. The request will include a letter and a routing sheet for a specific claim. The letter contains the key data from the claim (i.e., patient name, member number, patient account number and claim number), information requested, and the reason additional information is needed. This routing sheet serves as the fax cover sheet or cover page for documents that are mailed back to Florida Blue and is used for tracking purposes.

- The following are tips for submitting claim documentation when it is requested:
  - The Routing Sheet must be only used for the matching documentation. Do not copy the Routing Sheet for multiple claims; it is for a specific claim and member.
  - The Routing Sheet must always be the top sheet attached to the documentation regardless of the mode of return (i.e., fax, mail).
  - When the documentation is returned by fax, the Routing Sheet must be fed from the top of the page to the bottom of the page.
  - Do not attach separate sets together. Fax one information package at a time. Our electronic receiving system only recognizes the first page as the Routing Sheet and catalogues all subsequent pages accordingly.
  - Do not write on the Routing Sheet except to place an “X” within the applicable boxes to designate what type of documentation is attached to the Routing Sheet.
  - For records that contain greater than 100 pages, mail the documentation to P.O. Box 1798, Jacksonville, Florida 32231-0014. Package it with the Routing Sheet as the first page.
  - Do not send double-sided copies.
  - Do not return the original letter that was sent with the Routing Sheet.

Corrected Claims

A corrected claim is a claim that has already been processed, whether paid or denied, and is resubmitted with additional charges, different procedure or diagnosis codes or any information that would change the way the claim originally processed.

Claims returned requesting additional information or documentation should not be submitted as corrected claims. While these claims have been processed, additional information is needed to finalize payment.

Note: We do not consider a corrected claim to be an appeal.
Paper corrected claim:

- Submit a copy of the remittance advice with the correction clearly noted.
- If necessary, attach requested documentation (e.g., nurses notes, pathology report), along with the copy of the remittance advice. To ensure documents are readable, do not send colored paper or double-sided copies.
- Boldly and clearly mark the claim as “Corrected Claim”. Failure to mark your claim appropriately may result in rejection as a duplicate.
- If a modifier 25 or 59 is being appended to a CPT code that was on the original claim, do not submit as a "Corrected Claim". Instead, submit as a coding and payment rule appeal with the completed Provider Reconsideration/Administrative Appeal Form and supporting medical documentation (e.g., operative report, physician orders, history and physical).
- Attach the completed Provider Reconsideration/Administrative Appeal Form with your corrected claim.

Electronic corrected claim:

Providers with EDI or batch processing are able to electronically submit corrected claims to us via Availity. If you file these claims with the appropriate bill or frequency type codes listed below, then they can be included in your normal electronic submission process (e.g., HIS, PMS). Contact your vendor if you need assistance identifying the loop and segment for the type codes.

For institutional claims, use the three-digit Bill Type (XX7 or XX8) ending in the appropriate number.

For professional claims, use the appropriate number (7 or 8) for the Frequency Type.

7 – Replacement of Prior Claim
   If you have omitted charges or changed claim information (diagnosis codes, dates of service, member information, etc.), resubmit the entire claim, including all previous information and any corrected or additional information.

8 – Void/Cancel of Prior Claim
   If you have submitted a claim to Florida Blue in error, resubmit the entire claim. If the claim was paid, resubmit the claim to Florida Blue using the Claim Overpayment Refund Form.

Note: The feature is currently in development for providers who submit via Avdity’s web-based system and will be available in the future.
Claim Status

Providers may submit claim status inquiries for a variety of reasons (e.g., corrected claims, late charges, medical records, etc.). When submitting an appeal for a claim inquiry, complete the Provider Reconsideration/Administrative Appeal Form and attach it to your claim. A wide range of self-service options are available by Florida Blue to enable providers to view a summary of claims that have previously been paid, rejected or pended. Please refer to the Frequently Referenced Self Service Section for additional information on the self-service tools.

Claim Inquiry

Providers may submit inquiries on claims for a variety of reasons (e.g., corrected claims, late charges, medical records, etc.). When submitting a claim inquiry, complete the Provider Reconsideration/Administrative Appeal Form and attach it to your claim. A wide range of self-service options are available by Florida Blue to enable providers to view a summary of claims that have previously been paid, rejected or pended. Please refer to the Frequently Referenced Self Service Section for additional information on the self-service tools.

Rejected Claims

All paper claims go through “front-end” edits that verify eligibility information. Claims that cannot be scanned by Optical Character Recognition (OCR) will be returned to the provider with an accompanying explanation. If the claim is returned, it must be submitted as a new claim; not a “corrected” claim. Returned claims are rejected prior to processing; therefore, there is not an original claim to correct in the system.

Pharmacy Claim (Medical)

Submit claims for payment directly to Florida Blue following the guidelines below.

Drug Units

The drug units must always be included on the claim submission. The drug units should be based on the HCPCS code, not the NDC, unless a specific J code is not assigned to the drug.

Unclassified drug codes (J3490, J3590, J9999, J1599, etc.) must always be billed with the drug name, NDC and NDC units. The NDC should be provided in field 24G on a CMS-1500 and in loop 2410 segment LIN on an electronic 837 Professional claim submission. If you have additional questions on how to bill NDCs for electronic claim submission, please refer to NDC Quantity section within Coding a Professional Claim within the Provider Manual and/ or contact your software Management Company or clearinghouse. Failure to provide this information may delay claim processing.
Diagnosis

Include the primary diagnosis code on the claim, which is the reason for the drug use.

Claims submitted with only a V58.1 diagnosis code (Other and Unspecified After-Care Maintenance Chemotherapy) will require additional information prior to a coverage decision.

Modifiers

When billing the JW modifier, the claim line with the discarded quantity amount should only be identified.

At this time, the JW modifier is not required but accepted in order to identify the quantity being reported as drug wastage.

Claims should be submitted electronically through Availity or a clearinghouse. Medical Policies (Medical Coverage Guidelines) used for pre- and post-service review related to the specified drugs are available on Florida Blue’s website.

If you have additional questions or need to verify your current contractual agreements require you to participate in the PADP, contact Network Management.
HIPAA Version 5010 Updates and Helpful Tips

As of January 1, 2012, the electronic claims submission formats were upgraded from Version 4010/4010A1 to Version 5010. The upgraded Version 5010 transaction standards have different requirements than those of Version 4010 and 4010A.

Below are updates and helpful tips for processing your Version 5010 claims to avoid unnecessary rejections:

- National Provider Identifier (NPI): Previously, you were allowed to report an Employer’s Identification Number (Tax ID) or Social Security Number (SSN) as a primary identifier for the billing provider. For Version 5010 claims, you are only allowed to report an NPI as a primary identifier.
  - Before using your NPI to file claims, you must register it with Florida Blue. Simply complete and return the NPI Notification Form.

**Note:** For more specific information on how to bill, please refer to the below items:

- Billing Provider Address: You must use a physical street address for your Billing Provider Address. Version 5010 does not allow for use of a P.O. Box address for either professional or institutional claim formats. You can still report a P.O. Box as a pay-to address.
  - ZIP Code: You need to include a complete 9-digit ZIP code for the billing provider and service facility location. You should work with your software vendor or clearinghouse to make sure that your system captures the full 9-digit ZIP code.
- Florida Blue Proprietary ID: This number can no longer be submitted for electronic claims; the taxonomy and NPI are now required fields.
- Present on Admission (POA) Indicator: A POA indicator is now submitted in conjunction with diagnosis codes.
- Ambulance Services (pick-up/drop off): A valid postal zone or zip code is required when billing for ambulance or non-emergency transportation services.
- Anesthesia Services: Minutes are required for anesthesia claims.
- Coordination of Benefits (COB):
  - The Other Payer allowed amount can no longer be reported for electronic claims.
  - The Rules of Balancing now include the COB section of the claim.
- First Name: First name is not required when this information is not available/not known.
- Outpatient Claims: Outpatient claims now require a new segment “Patients Reason for Visit”.
- Diagnosis Qualifiers: Indicators have been added to distinguish between ICD-9 and ICD-10 codes in preparation for ICD-10 implementation.
Billing Guidelines
For a complete listing of Florida Blue's billing guidelines, please access the link to our Frequently Referenced Billing Section.

NetworkBlue Providers

Providers participating in NetworkBlue are reimbursed based on the terms of their Agreement for services to BlueOptions members and have agreed to accept the BCBSF allowed amount (less deductible, coinsurance, and/or copayment) as payment-in-full for covered services. When members access NetworkBlue providers, covered benefits are reimbursed at a higher benefit level and their coinsurance percentage is usually lower.

A member may choose any NetworkBlue hospital under a two-option design. Each option represents a different member cost sharing amount for hospital services. For inpatient services there is a per admission facility cost sharing, which could be a copayment or deductible and/or coinsurance; for outpatient services there is a per visit facility cost sharing, which could be a copayment or deductible and/or coinsurance. The option levels are based on the negotiated payment amounts with area hospitals and include efficiency and cost factors. The option ranges do not reflect on the quality of the facility.

Option 1 - Lowest facility member cost sharing

Option 2 - Higher facility member cost sharing

Members have less out-of-pocket costs when accessing Option 1 hospitals. Therefore, it is to the member’s financial advantage to receive services at an Option 1 hospital. NetworkBlue providers should refer, whenever possible, to the members’ choice of a NetworkBlue hospital.

For non-covered services, NetworkBlue providers may bill the member subject to any discounted rate which may be set forth in the NetworkBlue Agreement or the amount agreed to by the member and the provider, whichever is less.
Documentation of Care Review

The Florida Blue Documentation of Care (DOC) Medical Record Review provides an organized, systematic and coordinated approach to monitor and evaluate the quality and appropriateness of the Primary Care Physician’s (PCP) office medical record documentation. This annual review is designed to help improve PCP medical record-keeping practices to promote patient safety and improve continuity, coordination, and transition of care. The program is consistent with efforts to respond to customer expectations as well as accreditation and regulatory requirements by National Committee for Quality Assurance (NCQA), Agency for Health Care Administration (AHCA), Centers for Medicare and Medicaid Services (CMS), and Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). The DOC process aligns with NCQA review of the plan’s medical record files for survey regulatory review purposes.

Florida Blue conducts the DOC Review annually, in which a representative sample crossing all lines of business is randomly pulled from a dataset of members seen three or more times by the primary care physician. The population sample includes PPO, Florida Blue HMO (Health Options, Inc.), Medicare Advantage, Federal Employee Program® (FEP) and Affordable Care Act (ACA) plans.

A team of Florida Blue registered nurses performs the DOC Review against a set of 23 fixed quality indicators. In response to the audit, providers are mailed a result letter along with an educational packet (DOC guidelines and sample of pre-printed medical record tools). The focused follow-up letter identified areas of opportunity and encouraged providers to implement actions intended to improve documentation.

Guidelines for Primary Care Physician Medical Record Review

- The medical record is legible.
- Each page of office progress notes contains member name and identification number such as Florida Blue member ID, date of birth or physician office medical record ID number.
- The provider is identified on each entry in the record with a legible signature or initials.
- The medical record contains biographical data including date of birth, name, member identification number, and gender.
- The record contains a problem list or a summary of significant problems, medical diagnoses, and/or conditions and operative/invasive procedures.
- Current medications are documented on a medication list or listed in progress notes.
- Allergies and adverse reactions to medications are documented. If there are none, then documentation should indicate NKA (no known allergies).
- There is documentation whether or not the member age 18 and older has executed an advance directive.
- The main complaint or reason for each office visit is clearly stated.
- All entries of the progress notes are dated.
- Unresolved problems from previous office visits are addressed in subsequent visits.
- For pediatric/adolescent members (ages 16 and under) there is a completed, up-to-date immunization record in the chart.
- The medical record contains a past medical history.
- For members age 12 and older there is documentation of inquiry/counseling regarding tobacco use.
- For members age 12 and older there is documentation of inquiry/counseling regarding history of alcohol/substance abuse.
- The medical record contains a complete physical examination.
- Objective findings are documented, including appropriate vital signs.
- Diagnosis is supported by subjective and objective findings.
• There is a documented treatment plan that is consistent with the diagnosis.
• Laboratory, X-ray, and diagnostic studies are present in the record and reflect primary care review (signed, stamped, typed or electronic).
• Consultations present in the record reflect primary care review (signed, stamped, typed or electronic).
• Follow-up plans documented at each visit in the medical record.
• There is evidence that appropriate preventive screenings and services are completed for children and adults in accordance with Health Options' practice guidelines. Health Options has adopted guidelines from the USPSTF's Guide to Clinical Preventive Services. Visit the Agency for Healthcare Research and Quality website for the latest age/gender specific clinical recommendations.
Medical Pharmacy Services

Medical pharmacy services are contracted services covered through the medical benefit.

Note: Please refer to the Home Health section when pharmaceutical services are administered by a home health provider.

Refer to the appropriate Medication Guide, based upon the patient's plan, to determine if a specific drug is classified by Florida Blue as provider administered and/or self-administered. The Medication Guide also includes coverage requirements such as prior authorization for provider administered and self-administered drugs. Specific coverage criteria for medical pharmacy services can also be found in the Medical Policies (Medical Coverage Guidelines).

All pharmaceuticals covered under the medical benefit must be approved by the FDA in order to be considered for coverage.

Reimbursement Exception Drug Pricing - Unclassified Drug Payment Policy

The following list identifies the drugs Florida Blue has approved a Reimbursement Exception price to the Unclassified Drug Payment Policy (Payment Policy # 10-008).

The following drugs will be reimbursed based upon the specified pricing method listed below during the timeframe the Drug is assigned to an Unclassified Drug HCPCS. Once the Drug is assigned a listed HCPCS/CPT, the pricing identified will no longer apply, and the drug will be priced based upon the contract arrangements, if applicable.

Reimbursement Exception pricing listed below is only applicable for providers/suppliers that do not contract at the NDC level for all drugs.
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Drug NDC Code(s)</th>
<th>Unlisted HCPCS</th>
<th>NDC Qty (Unit of Measurement = UoM)</th>
<th>Pricing Method per NDC Qty</th>
<th>Term Date (Listed HCPCS Effective)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empliciti</td>
<td>57894-0502-05</td>
<td>J9999</td>
<td>(UoM = ML) 5ML = 1 vial</td>
<td>AWPU – 8%</td>
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<td></td>
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<td></td>
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<tr>
<td>Empliciti</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Yondelis</td>
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<tr>
<td>Onivyde</td>
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<tr>
<td>Drug Name</td>
<td>Drug NDC Code(s)</td>
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<td>NDC Qty (Unit of Measurement = UoM)</td>
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<td>Iluvien</td>
<td>68611-0190-02</td>
<td>J3490</td>
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<td>Blincyto</td>
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<td>Opdivo</td>
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<tr>
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<td>Drug NDC Code(s)</td>
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<tr>
<td>Aveed</td>
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<tr>
<td>Drug Name</td>
<td>Drug NDC Code(s)</td>
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<td>Pricing Method per NDC Qty</td>
<td>Term Date (Listed HCPCS Effective)</td>
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<td>Vimizim</td>
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<td>J1322 effective 01/01/2015</td>
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<td>Injectafer</td>
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<td>Q9970 effective 01/01/2015</td>
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<td>Gazyva</td>
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<td>Q0090 effective 07/01/2013 - 12/31/2013</td>
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<td>Kadcyla</td>
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<td>Jetrea</td>
<td>24856-0001-00</td>
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<td>Perjeta</td>
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<td>Pricing Method per NDC Qty</td>
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<td>WAC unit price</td>
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<td>Halaven</td>
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<td>Prolia</td>
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<td>J0897 effective 01/01/2012</td>
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<td>Drug NDC Code(s)</td>
<td>Unlisted HCPCS</td>
<td>NDC Qty (Unit of Measurement = UoM)</td>
<td>Pricing Method per NDC Qty</td>
<td>Term Date (Listed HCPCS Effective)</td>
</tr>
<tr>
<td>-----------</td>
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<td>----------------</td>
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</tr>
<tr>
<td>Yervoy</td>
<td>00003-2328-22</td>
<td>J9999</td>
<td>(UoM = ML) 40ML = 1 vial</td>
<td>WAC unit price</td>
<td>J9228 effective 01/01/2012</td>
</tr>
<tr>
<td></td>
<td>00003-2327-11</td>
<td></td>
<td>(UoM = ML) 10ML = 1 vial</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Claim Payments and Statements

Remittance Advice

The remittance advice provides you with claim payment and rejects information. When you file a claim, you can view your remit online using the Availity Remittance Viewer. If a payment is due, you will receive payment by check or Electronic Funds Transfer EFT. Claims are processed daily and combined into a weekly payment and remittance advice that is generated once a week based on the zip code of the provider's payment address for the claim. Capitation is paid once a month (by the 15th of the month). These dates are subject to change.

Separate remittance advices are generated for each separate payment address by the following lines of business or special groups:

- PPO/Traditional (including BlueCard)
- Federal Employee Program (FEP Basic, FEP Standard and FEP Blue Focus)
- State Employees’ PPO Plan
- Florida Blue HMO
- Various ASO accounts

If you file electronically, you can receive the 835 ERA upon request. Refer to the Health Care Payment/Advice section for additional information on how to start receiving the 835.
Overpayment Recovery

For claims subject to Florida law, refer to Florida Statutes Sections 627.6131 and 641.3155

Certain claims, including claims for members covered by the Federal Employees Health Benefit Plan, Self-Insured health benefit plans subject to the provisions of ERISA, and Medicare Advantage are not subject to the provisions of Florida law.

An overpayment is reimbursement in excess of the monetary obligation that we have with respect to a particular claim. Florida Blue pursues timely recovery of all identified overpayments using various methods.

Offsetting Policy

We use a payment offsetting policy to recover claim overpayments. We recover the overpaid amount by offsetting (deducting) it from current or future claim payment(s). In other words, the overpaid amount is subtracted from the payment for claims on a subsequent remittance.

Before offsetting, if applicable, we follow state law, which requires advance notification of the intent to recover overpayments through an offsetting process. According to their Agreement with us, participating providers are required to promptly notify Florida Blue of claims processing or payment errors and allow for the use of offsetting/recouping overpayments.

Timeframe for Requesting Overpayments

For claims subject to Florida law, refer to Florida Statutes Sections 627.6131 and 641.3155.

Certain claims, including claims for members covered by the Federal Employees Health Benefit Plan, Self-Insured health benefit plans subject to the provisions of ERISA and Medicare Advantage, are not subject to the provisions of Florida law.

Florida Blue or Florida Blue HMO Identified Overpayments

All refunds of overpayments in response to overpayment requests received from us or one of our contracted vendors should be sent to the name and address of the entity outlined on the refund request letter. Please include appropriate documentation that outlines the overpayment, including customer’s name, health care ID number, date of service and amount paid. If possible, please include a copy of the remittance advice that corresponds with the payment from us. If the refund due is a result of coordination of benefits with another carrier, provide a copy of the other carrier’s EOB with the refund.

When we determine that a claim was paid incorrectly, we may make claim adjustments without requesting additional information from participating health care providers. In the case of an overpayment, we will request a refund at least 30 calendar days prior to implementing a claim adjustment, or as provided by applicable law. You will see the adjustment on the EOB or RA. When additional or correct information is needed, we will ask you to provide it.
We provide advance notification of the intent to recover overpayments by sending a refund request letter. Information contained in the letter includes:

- Claim(s) that were overpaid
- Overpayment reason
- Overpayment amount
- Corresponding member information

**Actions to complete upon receipt of the refund request letter**

- Review the letter for the appropriate request reason and claim data.
- Contact the Provider Contact Center if additional basic information is needed to process the refund.
- Submit a refund within 40-days.
- At a minimum, clearly notate the following information associated with the refund payment:
  - Member ID number
  - Claim number
  - Date of service
  - Patient name
  - Patient account number
  - Invoice number (preferred)
- Notify us in writing, within 35-days of letter receipt, if the overpayment request is being contested or denied. Clearly notate the contested or denied portion of the claim overpayment request and provide the specific reasoning.

**Provider Identified Overpayments**

If you identify a claim for which you were overpaid, you must send the overpayment within 30 calendar days from the date of your identification of the overpayment. If, however, you fail to do so, we may request such payment. If we do not receive payment within 45 days of our request for payment in writing, we may recover such overpayment, to the extent permitted by applicable law, including but not limited to, by offsetting against future claim payments.

Providers have two options when an overpayment has been made and we have not yet recovered the funds:

**Option 1: Contact the Provider Contact Center**

- Call the Provider Contact Center to request a refund letter.
- Submit a corrected claim if the original claim data is being changed.
- Upon receipt of the refund letter, follow the steps outlined in the above Florida Blue Identified Overpayments section.
Option 2: Refund the overpayment

When an overpayment applies to only one or some of the claims associated with a check:

- Cash the check and issue a personal/company check to us for the overpaid amount.
- Complete the Claim Overpayment Refund Form
- Send the issued check, refund form and any other documentation such as corrected claim, remittance advice, and other carrier’s explanation of benefits with affected claims circled.

Overpayment applies to all claims

When an overpayment applies to all claims associated with a check:

- Return the check
- Complete the Claim Overpayment Refund Form
- Send the check, refund form and any other documentation such as corrected claim, remittance advice, and other carrier’s explanation of benefits with affected claims circled.

Return Address for Return Checks

Florida Blue
Department 1213
PO Box 121213
Dallas, TX 75312-1213

Express Courier Service (e.g., DHL, FedEx, UPS, etc.), send checks to:

Florida Blue
Lock Box 891213
1501 North Plano RD
Richardson, TX 75081
Subrogation and Coordination of Benefits

Our benefit plans are subject to subrogation and Coordination of Benefits (COB) rules.

**Subrogation** — To the extent permitted under applicable state and federal law and the applicable benefit plan, we reserve the right to recover benefits paid for a member’s health care services when a third party causes the member’s injury or illness. In accordance with Florida Statute 768.76 a member/attorney must advise Florida Blue if they’re seeking reimbursement from a 3rd party liability.

**Coordination of Benefits (COB)** — COB is administered according to the Customer’s benefit plan and in accordance with applicable law. We accept secondary claims electronically. COB or Health Order Liability (HOROL) is the member’s responsibility to provide other insurance information to us. Providers can access the Other Insurance Form and also request copies of our COB brochure. Members who do not update other insurance information may have their claims denied and will be responsible for the charges. Providers may bill the member for services that were denied for lack of other insurance information.

**Billing Primary and Secondary Insurance**

<table>
<thead>
<tr>
<th>Primary Insurer</th>
<th>The coverage provided by the member’s employer is usually considered the primary carrier. See the following COB general rules for additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim to Primary Insurance Carrier</td>
<td>Include all other insurance carrier information in the appropriate COB fields of the electronic form: CMS 1500= blocks 9 a-d CMS UB-04 = 50 A-C</td>
</tr>
<tr>
<td>Claim to Secondary Insurance Carrier</td>
<td>When Florida Blue is the secondary carrier, file the claim to Florida Blue on the member’s behalf after the primary insurance has completed processing. Include all other insurance carrier information in the appropriate COB fields of the electronic form and attach a copy of the other carrier’s remittance advice. CMS 1500= blocks 9 a-d CMS UB-04 = 50 A-C</td>
</tr>
<tr>
<td>Collect Deductible, Coinsurance, Copayment and/or Non-Covered Services Amounts</td>
<td>The terms of your Agreement apply whether the member’s Florida Blue policy is primary or secondary. Deductibles and coinsurance amounts should be based on the lower of the Florida Blue allowance or the provider’s charge. Florida Blue’s payment along with other payments shall not exceed 100 percent of the rates agreed upon in the provider agreement. <strong>Note:</strong> Do not balance bill the member. It is recommended to collect the coinsurance amount from the member after payments from both insurance companies have been received.</td>
</tr>
</tbody>
</table>
## Coordination of Benefits Rules

<table>
<thead>
<tr>
<th>COB Rules</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>May vary by contract (rules below do not cover every situation)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contract Holder/Spouse</th>
<th>The plan without a COB provision pays before a plan with a COB provision.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note:</strong></td>
<td>In cases involving Medicare, primary/secondary status is subject to the Medicare secondary payer rules (see COB with Medicare), which further determine order of liability based on group size and Medicare eligibility reason.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Active/Inactive Rule</th>
<th>The benefits of a plan covering a person who is neither laid off nor retired pays before a plan that covers a person who is laid off, retired or inactive. This rule does not supersede the dependent rule.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dependent Children</th>
<th>Submit to the parent’s plan whose birth date, based on month and day, falls earliest in the year, disregarding the year of birth.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For example: The mother’s date of birth is April 1, 1950 and the father’s is August 7, 1948. Submit to the mother’s plan first.</td>
</tr>
<tr>
<td></td>
<td>If the parents of the child are divorced or legally separated, submit first to the plan of the parent with financial responsibility for health care coverage per the court decree.</td>
</tr>
<tr>
<td></td>
<td>If not stated in the decree, submit bills in the following order:</td>
</tr>
<tr>
<td></td>
<td>The plan of the parent with custody</td>
</tr>
<tr>
<td></td>
<td>The plan of the spouse of the parent with custody</td>
</tr>
<tr>
<td></td>
<td>The plan of the natural parent without custody</td>
</tr>
<tr>
<td></td>
<td>The plan of the spouse of the parent without custody</td>
</tr>
</tbody>
</table>
### Other Coordination of Benefit Information

<table>
<thead>
<tr>
<th>Other COB Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Auto</strong></td>
</tr>
<tr>
<td><strong>In general:</strong> No Fault Auto insurance provides coverage for losses sustained as a result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle. Payments for such claims are made by the carrier that provides coverage for the owner or driver of the vehicle in which the injured party was a passenger. Florida Blue would pay as primary until the PIP deductible has been satisfied. The auto carrier would then assume the responsibility of the primary payer up to policy limits.</td>
</tr>
<tr>
<td>If the auto carrier denies payment due to exclusion under its contract:</td>
</tr>
<tr>
<td>The notice of the rejected claim must be submitted with claims to Florida Blue.</td>
</tr>
<tr>
<td>An injured party may elect to reserve PIP coverage for lost wages. Notice of the reservation must be submitted with claims to Florida Blue.</td>
</tr>
<tr>
<td>A participating provider may not elect to withhold claims for members with Florida Blue insurance coverage in favor of collecting from settlement proceeds from an injury where there is third party liability. To do so constitutes balance billing and is a breach of contract for participating providers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Automobile Accident Claim Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit the claim to auto insurance carrier unless the patient states they have no PIP coverage.</td>
</tr>
<tr>
<td>Members without PIP coverage must write a statement to the provider’s office indicating such.</td>
</tr>
<tr>
<td><strong>Note:</strong> PIP coverage is required in order to have a valid Florida Driver's license.</td>
</tr>
<tr>
<td>The statement must be signed and dated by the member.</td>
</tr>
<tr>
<td>Submit the claim to Florida Blue using the Health Insurance Claim Form (CMS-1500) and/or the UB-04 claim form.</td>
</tr>
</tbody>
</table>
Other Coordination of Benefit Information Cont’d

<table>
<thead>
<tr>
<th>Other COB Information</th>
<th>Complete member information and all applicable fields:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS-1500 Form Guidelines</td>
<td>Complete member information and all applicable fields:</td>
</tr>
<tr>
<td><strong>Note:</strong> Florida Blue’s Other Party Liability department may contact the member or automobile insurance carrier for additional information.</td>
<td>- Enter “yes” in box 10-B</td>
</tr>
<tr>
<td></td>
<td>- Enter the accident date in field 14</td>
</tr>
<tr>
<td></td>
<td>- Enter all diagnosis codes in section 21</td>
</tr>
<tr>
<td></td>
<td>- Attach the following to the claim:</td>
</tr>
<tr>
<td></td>
<td>- Copy of the check</td>
</tr>
<tr>
<td></td>
<td>- EOB</td>
</tr>
<tr>
<td></td>
<td>- Provide a copy of the Exhaustion letter from primary insurance carrier</td>
</tr>
<tr>
<td></td>
<td>- Statement from member indicating no PIP coverage</td>
</tr>
<tr>
<td></td>
<td>- PIP worksheet (if available)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UB-04 Form Guidelines</th>
<th>Complete member information and all applicable fields:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note:</strong> Florida Blue’s Other Party Liability department may contact the member or automobile insurance carrier for additional information.</td>
<td>- Enter the occurrence codes and accident date in fields 33-35 use code 01 or 02</td>
</tr>
<tr>
<td></td>
<td>- Enter the condition code in fields 18-28 use code 03</td>
</tr>
<tr>
<td></td>
<td>- Enter the value codes in field 39-41 use code 14</td>
</tr>
<tr>
<td></td>
<td>- Enter all diagnosis codes in fields 67-76</td>
</tr>
<tr>
<td></td>
<td>- Enter the E-diagnosis codes in field 77</td>
</tr>
<tr>
<td></td>
<td>- Attach the following to the claim:</td>
</tr>
<tr>
<td></td>
<td>- Copy of the check</td>
</tr>
<tr>
<td></td>
<td>- EOB</td>
</tr>
<tr>
<td></td>
<td>- Provide a copy of the Exhaustion letter from primary insurance carrier</td>
</tr>
<tr>
<td></td>
<td>- Statement from member indicating no PIP coverage</td>
</tr>
<tr>
<td></td>
<td>- PIP worksheet (if available)</td>
</tr>
</tbody>
</table>
### Other COB Information

| Additional Information | The coverage provided by the member's employer is usually considered the primary carrier. See the following COB general rules for additional information.  
Include all other insurance carrier information in the appropriate COB fields of the electronic form:  
CMS 1500= blocks 9 a-d  
CMS UB-04 = 50 A-C  
When Florida Blue is the secondary carrier, file the claim to Florida Blue on the member's behalf after the primary insurance has completed processing. Include all other insurance carrier information in the appropriate COB fields of the electronic form and attach a copy of the other carrier's remittance advice.  
CMS 1500= blocks 9 a-d  
CMS UB-04 = 50 A-C  
The terms of your Agreement apply whether the member's Florida Blue policy is primary or secondary.  
Deductibles and coinsurance amounts should be based on the lower of the Florida Blue allowance or the provider's charge.  
Florida Blue's payment along with other payments shall not exceed 100 percent of the rates agreed upon in the provider agreement.  
**Note:** Do not balance bill the member. It is recommended to collect the coinsurance amount from the member after payments from both insurance companies have been received. |
|---|---|

# Worker's Compensation

## Other COB Information

<table>
<thead>
<tr>
<th>Workers' Compensation Claim Submission</th>
<th>If the services are work related, submit the claim to the worker’s compensation insurance carrier. After the worker’s compensation insurance carrier has processed the claim, submit the claim to Florida Blue using the Health Insurance Claim Form (CMS-1500) and/or the UB-04 claim form.</th>
</tr>
</thead>
</table>
| CMS-1500                               | Complete member information and all applicable fields:  
  • Enter "yes" in box 10-B  
  • Enter the accident date in field 14  
  • Enter all diagnosis codes in section 21  
  • Attach the following to the claim:  
    • Copy of the check  
    • EOB  
    • Provide a copy of the Exhaustion letter from primary insurance carrier  
    • Statement from member indicating no PIP coverage  
    • PIP worksheet (if available) |

**Note:** Florida Blue’s Other Party Liability department may contact the member or automobile insurance carrier for additional information.
Coordination of Benefits with Medicare Group Plans

Medicare is Primary

If Medicare is primary and Florida Blue or another Blue Plan is secondary, submit the claim with the Medicare Remittance Advice and following information:

**BlueMedicare**

Providers contracted at a percentage of the Skilled Nursing Facility or inpatient payment system amount should submit the following:

- Type of bill “18X” or “21X”
- HIPPS RUG codes – units should reflect the number of covered days for each code
- Revenue code 0022 – charges are not required
- Additional revenue codes representing services provided can be submitted on the claim

Providers contracted under a Florida Blue inpatient per diem arrangement should submit the following:

- Type of bill “18X” or “21X”
- Revenue codes 191-194 or 199
- Units should reflect the number of covered days for the SNF stay
- Additional revenue codes representing services provided can be submitted on the claim

**Note:** Medicare Advantage plans replace Medicare coverage; therefore Florida Blue is primary for BlueMedicare HMO and BlueMedicare Select members.

Medicare is not the Primary Payer

To ensure accurate payment and processing for Florida Blue and other Blue Plan primary claims, which includes MA plans, submit claims with the following information:
### Coordination of Benefits (COB) Medicare products

The following are examples of when group insurance would pay before Medicare:

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Working Aged</strong></td>
<td>If the employee, or employee’s spouse, has Medicare coverage due to age (65 and older), and either or both are actively employed through an employer with 20 or more full-time, part-time and/or leased employees, their group health insurance through active employment must pay first.</td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td>Employees, or their dependents, which are entitled to Medicare due to a disability other than ESRD, and are actively employed or who are covered as a dependent through an employer that employs 100 or more full-time, part-time and/or leased employees, their group health insurance through active employment must pay first.</td>
</tr>
<tr>
<td><strong>End Stage Renal Disease</strong></td>
<td>Employees, or their dependents, which are entitled to Medicare due to ESRD, who have employer group health plan coverage through current or former employment (this means active, retiree or COBRA policies) with an employer of any size, must have group insurance as the primary payer for the first thirty months of entitlement to Medicare. Thereafter, Medicare will be primary.</td>
</tr>
<tr>
<td><strong>Entitled to Medicare for More Than One Reason When One Reason is ESRD (Dual Entitlement)</strong></td>
<td>Entitlement to Medicare for more than one reason does not make Medicare the primary payer if one of the reasons is ESRD. The ESRD rule prevails and group insurance is the primary payer. If Medicare is primary prior to the individual becoming eligible due to ESRD, then Medicare will remain primary (e.g., persons entitled due to disability whose employer has less than 100 employees or retirees over the age of 65). If the group insurance is primary prior to ESRD entitlement, then the group will remain primary for the ESRD coordination period for the first 30 months of an individual entitlement for Medicare benefits on the basis of ESRD regardless of current reason for entitlement.</td>
</tr>
</tbody>
</table>
### Other COB Information

**UB-04 Form Guidelines**

- Enter the occurrence codes and accident date in fields 33-35 use code 01 or 02
- Enter the condition code in fields 18-28 use code 03
- Enter the value codes in field 39-41 use code 14
- Enter all diagnosis codes in fields 67-76
- Enter the E-diagnosis codes in field 77
- Attach the following to the claim:
  - Copy of the check
  - EOB
  - Provide a copy of the Exhaustion letter from primary insurance carrier
  - Statement from member indicating no PIP coverage
  - PIP worksheet (if available)

**Note:** Florida Blue’s Other Party Liability department may contact the member or automobile insurance carrier for additional information.
When submitting a paper corrected claim, follow these steps:

- Submit a copy of the remittance advice with the correction clearly noted.
- If necessary, attach requested documentation (e.g., nurses notes, pathology report), along with the copy of the remittance advice. To ensure documents are readable, do not send colored paper or double-sided copies.
- Boldly and clearly mark the claim as “Corrected Claim”. Failure to mark your claim appropriately may result in rejection as a duplicate.
- If a modifier 25 or 59 is being appended to a CPT code that was on the original claim, do not submit as a Corrected Claim*. Instead, submit as a coding and payment rule appeal with the completed Provider Appeal Form and supporting medical documentation (e.g., operative report, physician orders, history and physical).
- Attach the completed Provider Inquiry / Reconsideration Form with your corrected claim.

**Note:** Florida Blue does not consider a corrected claim to be an appeal.
Appeals

An appeal refers to the procedures that deal with the review of adverse organization determinations for the health care services a member is entitled to receive, or any amounts that the member must pay for a service. These procedures include reconsiderations by the MA organization, an independent review entity, and hearings before Administrative Law Judges (of the Social Security Administration) or review by the board of judicial review.

A member has the right to appeal any adverse benefit determination made by Florida Blue for:

- Payment for emergency services, post-stabilization care, urgently needed services, or temporarily out-of-area renal dialysis;
- Failure to approve, furnish, arrange for, or provide payment for, in whole or in part, services the member believes should be covered; or
- Discontinuation of services that the member believes is medically necessary / appropriate and should be continued.

Members are now allowed to challenge national coverage determinations and local coverage determinations. A member can only seek review if he or she needs a service(s) that is applicable to a national or local coverage determination as documented by the treating provider.

Florida Blue has a standard organization determination and appeals procedure and an expedited appeals procedure. Details are summarized on the following pages.

Reconsideration is the First Step in the Appeal Process

Reconsideration consists of a review by Florida Blue of an adverse organization determination, the evidence and findings upon which it was based, and any other evidence the parties submit or Florida Blue or CMS obtains.

There are two types of reconsideration - standard and expedited. A standard reconsideration can be requested by the member or their designated representative; an assignee of the member (a physician or other provider who has furnished a service to the member and formally agrees to waive any right to payment from the member for that service); a legal representative of a deceased member’s estate; any other provider or entity (other than Florida Blue) determined to have an interest in the appeal proceeding; or any other provider or entity (other than Florida Blue) whose rights with respect to the organization determination may be affected by the reconsideration as determined by the entity that conducts the reconsideration. Contracted providers are required to submit a signed authorization of representation in order to be a party to reconsideration, except in expedited requests.
Standard Reconsideration Requests

There are two categories of standard reconsideration - services or payment. A request for reconsideration must be filed in writing within 60 calendar days of the organization determination notification date. The 60-day timeframe may be extended if the requester submits the request in writing and shows a good cause for why the request was not filed on time.

1. For Services:

Original adverse organization determination overturned:

If the Florida Blue reconsideration determination is completely favorable to the member, Florida Blue must issue the determination and effectuate it (authorize or provide service under dispute) as expeditiously as the member’s health condition requires, but no later than 30 calendar days (or no later than expiration of an extension of up to 14-days) from the date request is received. Florida Blue may extend the 30-day time frame by up to 14 calendar days if requested by the member or if Florida Blue justifies a need for additional information and how the delay is in the interest of the member.

Original adverse organization determination upheld:

If the Florida Blue reconsideration determination confirms, in whole or part, the adverse determination under appeal, Florida Blue must submit a written explanation and the case file to the independent entity contracted by CMS as expeditiously as the member’s health condition requires, but no later than 30 calendar days (or no later than expiration of an extension of up to 14-days) from the date the request is received. Florida Blue may extend the 30-day time frame by up to 14 calendar days if requested by the member or if Florida Blue justifies a need for additional information and how the delay is in the interest of the member.

2. For Payment:

Original adverse organization determination overturned:

If the Florida Blue reconsideration determination is completely favorable to the member, Florida Blue must issue the determination and pay for the service under dispute no later than 60 calendar days from the date the request was received.

Original adverse organization determination upheld:

If the Florida Blue reconsideration confirms, in whole or part, the adverse determination under appeal, Florida Blue must submit a written explanation and the case file to the independent entity contracted by CMS no later than 60 calendar days from the date the request was received.
PROVIDER APPEALS

Providers may request reconsideration of how a claim processed, paid or denied. These requests are referred to as appeals. Florida Blue will conduct a one-time appeal review, there is no second level appeal rights for a post-service provider appeal.

Florida Blue has a defined Provider Appeal process for use by providers who are dissatisfied with how a claim processed, paid or denied. Provider Appeal categories are:

- Clinical Appeals
- Non-Clinical Appeals (Coding appeals)
- Administrative

Appeal Appropriateness

Providers may send an appeal if there is financial liability for the provider or the provider is sending the appeal on behalf of the member (patient). If the provider is sending a post-service appeal on behalf of the member the Florida Blue Appointment of Representation (AOR) form must be completed and accompany the appeal. The appeal will then be processed as a member appeal.

Exception Process:

The provider may submit the appeal request without an AOR form when the following conditions are met:

1. The Provider is unable to reach the member to complete the AOR form.
2. The member refuses to submit payment to providers for services that have been rendered and a claim has been denied.
3. If one or both of these conditions are met, the provider can submit the appeal and must:
   a. Describe the contact attempts to the member with dates
   b. Describe the interaction with the member with dates regarding payments as indicated in number 2.

Please note:

1. Clinical appeals/Non-Clinical appeals: Providers must not re-appeal decisions to Florida Blue that have already been processed as an appeal. Providers are required to submit ALL documentation at the time of the appeal submission.
2. Administrative appeals: For reconsiderations of administrative appeals please follow the process noted in the Administrative Appeals process below.
3. Claims reprocessing is not an appeal. If the provider would like to submit a claim to be re-processed please follow the directions in the Claim Reimbursement section of the provider manual.
4. A physician or physician group must submit all documentation reasonably needed to decide the internal appeal to Florida Blue’s Provider Appeal and Dispute Department.
Participating providers must submit appeals within one year of the date that appears on the respective remittance advice. Florida Blue will not overturn claim denials based on the provider’s failure to comply with required procedures and time frames.

Non-Participating providers submitting appeals for Medicare Advantage denials are required to submit your appeal in writing within 60 calendar days from the date of the remittance.

Providers may not balance bill members for covered services; including disputed amounts.

If an appeal is approved or denied, a letter is sent informing you of the decision. If approved, the claim is forwarded for adjustment and/or payment.

**Clinical Appeals**

Clinical Appeals encompass claims that require clinical review. Clinical Appeal options (as referenced on the [Provider Clinical Appeal Form](#)) are:

- Non-Participating Providers with Florida Blue Medicare Advantage Appeals
- Utilization Management Appeals
- Adverse Determination Appeals (Medical Necessity or Experimental / Investigational Appeal)

**Non-Clinical Appeals**

Non-Clinical Appeals encompass claims that do not require clinical review. Non-Clinical Appeal options (as referenced on the [Provider Clinical Appeal Form](#)) are:

- Coding and Payment Rule Appeals

**Administrative Appeals**

Administrative Appeals encompass claims that do not require clinical review. Administrative Appeal options (as referenced on the [Provider Reconsideration/Administrative Appeal Form](#)) are:

- Claim Allowance Appeal
- Coordination of Benefits Appeal
- Provider Contract Issue Appeal
- Timely Filing Appeal
- Other
New Directions Behavioral Health Appeals Contact Information:

New Directions Behavioral Health
Attn: Appeals
PO Box 6729
Leawood, KS  66206
Phone: 866-730-5006
Fax: # is 816-237-2382

Administrative Appeals

Administrative Appeals encompass claims that do not require clinical review. Administrative Appeal options (as referenced on the Provider Reconsideration/Administrative Appeal Form) are:

- Claim Allowance Appeal
- Coordination of Benefits Appeal
- Provider Contract Issue Appeal
- Timely Filing Appeal
- Other

The Provider will check one of the applicable Administrative Appeal Types as listed below:

- Claim Allowance
- Coordination of Benefits
- Provider Contract Issue
- Timely Filing
- Other

Examples of “Other” Administrative Appeals include but are not limited to:

- Out-of-network provider requesting additional payment without changing the claim's original billing information.
- Claims denied as being outside the provider’s scope of service or contract
- Claims denied as services not payable under provider agreement
- Claims denied as services are not eligible for reimbursement
- Claims are for a non-Florida Blue or non-Florida Blue HMO member (other Blue Plan)
Administrative Appeals should be sent to the address below with the following information:

- The completed Administrative Appeal sections on the Provider Reconsideration/Administrative Appeal Form
- A written explanation supporting the Administrative Appeal
- A copy of the remittance advice
- The necessary documentation to support the Administrative Appeal
- The Reconsideration reference number documented in the Reconsideration letter from Florida Blue

Send all Administrative Appeals to

Florida Blue
P.O. Box 1798
Jacksonville, FL 32231

Pre-Service Appeals

A physician shall use the member appeal form for pre-service appeals if they are appealing on behalf of a Florida Blue member. Except for urgent pre-service Appeals, authorization must be obtained from the Florida Blue member in writing. Pre-service appeals will be handled by Florida Blue under the appeal process available to its member based on the terms of that member's contract or policy and the applicable state and federal laws and regulations.

Post-Service Appeals

An adverse determination post-service appeal must be submitted in writing within one year of date of payment and sent to the address below with the following information:

- The completed Provider Clinical Appeal Form
- A written explanation supporting the procedure code(s) appealed
- A copy of the remittance advice
- The necessary medical documentation (e.g., operative report, physician orders, history and physical) as indicated by the reason for the reduction or the denial on the remittance advice

The provider or provider group may not initiate on behalf of the member a post-service appeal of any denied service or supply if:

- Florida Blue's member (or his or her representative) or the provider or provider group filed a pre-service appeal pertaining to the same denied service; or
- Florida Blue's member (or his or her representative) is currently seeking or has sought a review or filed litigation related to the same denied service. In the event either Florida Blue’s member (or his or her representative) and the provider or provider group seek review of the same denied service, Florida Blue's member appeal shall go forward and the provider or provider group appeal will be dismissed.
- To be considered by the IRO, a physician or physician group must submit a written request for external review (i.e., adverse determination dispute) to the IRO within 60 calendar days from the date of the internal adverse determination appeal denial decision by Florida Blue with the appropriate fee.
A provider may file a written request with Florida Blue for appeal of a denial of payment because a proposed, or actual, health care service or supply was not medically necessary, was experimental or investigational, was supportive of an experimental or investigational, or was supportive of a not medically necessary procedure ("adverse determination appeal"). An adverse determination appeal can be a preservice or post-service claim if the requirements outlined below are met. An adverse determination appeal must be in writing and is not triggered by claim status requests or telephone inquiries regarding the application of benefits or allowed amount.

The Florida Blue Plan member would need to satisfy the above in order to seek external review under the terms of the applicable health benefit plan.

Send adverse determination appeals to

Florida Blue
Provider Disputes Department
P.O. Box 44232
Jacksonville, FL 32231-4232

Adverse Determination Appeals

A provider may file a written request with Florida Blue for reconsideration of a denial of payment because a proposed, or actual, health care service or supply was not medically necessary, was experimental or investigational, was supportive of an experimental or investigational, or was supportive of a not medically necessary procedure ("adverse determination appeal"). An adverse determination appeal can be a preservice or post-service claim if the requirements outlined below are met. An adverse determination appeal must be in writing and is not triggered by claim status requests or telephone inquiries regarding the application of benefits or allowed amount.

Adverse Determination External Review Process

The adverse determination external review process will provide an Independent Review Organization (IRO), to resolve disputes with physicians and physician groups arising from Florida Blue’s determination that certain services are not covered because they are not medically necessary, experimental or investigational in nature, supportive of an experimental or investigational procedure, or supportive of a not medically necessary procedure ("Adverse Determination Disputes"). The external review process is only available if Florida Blue's makes the Adverse Determination and administers its Plan Member appeals and/or external review process. Additionally, the Adverse Determination External Review Process is only available if Florida Blues upholds its initial Adverse Determination through the internal Appeals process and the cost of the service at issue exceeds the threshold amount, if any the Florida Blue’s Plan member would need to satisfy in order to seek external review under the terms of the applicable health benefit plan.
The IRO’s external reviewer shall be of the same specialty (but not necessarily the same sub-specialty), as the appealing physician, if applicable.

The provider or provider group may not initiate an adverse determination dispute of any denied service if:

- Florida Blue’s member is covered under a Self-Insured Plan and the Plan sponsor has not agreed by contract to participate in the adverse determination dispute process
- Florida Blue’s member is covered by a Federal Employee Health Benefit Agreement.

Instructions for requesting an external review can be found in the denial letter sent after the initial appeal review.

Coding and Payment Rule Appeal

A coding and payment rule appeal is a written request from a licensed health care practitioner for reconsideration of a health care claim based on Florida Blue’s application of its coding and payment rules and methodologies (including without limitation any bundling, down coding, application of a CPT modifier, and/or other reassignment of a code by Florida Blue).

They do not refer to:

- Pre-service review
- Concurrent review
- Claim status requests
- Other types of provider communication (e.g. telephone inquiries)

Claims processed after the implementation date of a new or revised coding edit and/or payment rule, regardless of service date(s), will process according to the updated version. No retrospective claim payment changes are made for processing changes that are the result of new code editing rules.

If the physician/provider disagrees with the processing of the claim, or Florida Blue’s edit logic overall (not case-specific), provide a written statement of the appeal, along with the following information:

- The completed Provider Clinical Appeal Form
- A written explanation supporting the procedure code(s) appealed
- A copy of the remittance advice attached
- The necessary medical documentation (e.g., operative report, physician orders, history and physical) as indicated by the reason for the reduction or the denial on the remittance advice
- Documentation from a recognized authoritative source that supports your position on the procedure codes submitted (optional)

Send Coding and Payment Rule Appeals to

Florida Blue
Provider Disputes Department
P.O. Box 44232
Jacksonville, FL 32231-4232
Utilization Management Appeals

UM appeal is a written request from providers to review a claim that required an authorization, pre-service review or precertification affecting a claim’s payment. This does not include provider appeals of pre-service determinations (unless required under ERISA), claims status requests, telephone inquiries or post-service claims review regarding the application of benefits or allowed amounts.

UM appeals must be filed pursuant to the timeliness requirements of the applicable Agreement with Florida Blue or within one year from payment date. Florida Blue will not overturn administrative claim denials based on the provider’s failure to comply with required procedures and time frames.

UM appeals should be sent to the address below with the following information:

- The completed Provider Clinical Appeal Form
- A written explanation supporting the procedure code(s) appealed
- A copy of the remittance advice
- The necessary medical documentation (e.g., operative report, physician orders, etc.) as indicated by the reason for the reduction or the denial on the remittance advice

Send UM appeals to:

Florida Blue
Provider Disputes Department
P.O. Box 44232
Jacksonville, FL 32203-3237
Member Appeal Review Process

In order to begin the formal review process, the member must complete, and submit to the local Florida Blue and Florida Blue HMO office at the address below, a Grievance/Appeal Form or a letter explaining the facts and circumstances relating to the grievance/appeal. The member should provide as much detail as possible and attach copies of any relevant documentation. While a member is not required to use a Grievance/Appeal Form, we strongly urge that a member submit the grievance/appeal on such a form in order to facilitate logging, identification, processing, and tracking of the grievance/appeal through the formal review process. A member may obtain these or other necessary forms by contacting us at the customer service number listed on the ID card.

If the grievance or appeal results from an adverse benefit coverage determination regarding medical necessity/appropriateness, a committee consisting of a majority of physicians will review the grievance/appeal. In this instance, the member must submit his/her grievance or appeal within 30 calendar days of notice of Florida Blue’s coverage determination. All other grievance or appeals must be filed with us within one year of the date of the occurrence that initiated the grievance or appeal. The local office will review a member’s grievance or appeal and advise the member of its decision in writing. If the grievance or appeal involves a pre-service claim, our decision regarding the grievance or appeal will be made within 30 calendar days of receipt of the grievance or appeal. For post-service claims and other grievances, our decision will be made within 60 calendar days of receipt of the grievance or appeal.

Florida Blue HMO Member Appeal General Rules

General rules regarding Florida Blue HMO (Health Options, Inc.) grievance and appeal process include the following:

A grievance or appeal must be filed with Florida Blue HMO within one year of the date of the occurrence that initiated the grievance or appeal. In order for grievances or appeals concerning adverse benefit coverage determinations based upon medical necessity/appropriateness to be reviewed by a committee consisting of a majority of providers, the member must submit the grievance or appeal within 30 calendar days from the receipt of Florida Blue HMO’s coverage determination.

A member must cooperate fully with Florida Blue HMO in its effort to promptly review and resolve a complaint, grievance or appeal. In the event the member does not fully cooperate with Florida Blue HMO, the member will be deemed to have waived his or her right to have the complaint, grievance or appeal processed within the time frames set forth above.

Florida Blue HMO shall offer to meet with the member if the member believes that such a meeting will help Florida Blue HMO resolve the grievance or appeal to the member’s satisfaction. The meeting will be held at Florida Blue HMO’s local office within the service area or at such other mutually agreeable location within the service area that is convenient to the member. The member may elect to meet with Florida Blue HMO representatives in person, by telephone conference call, or by video-conferencing (if facilities are available). Appropriate arrangements will be made to allow telephone conferencing or video conferencing to be held at the administrative offices of Florida Blue HMO within the service area. Florida Blue HMO will make arrangements with no additional charge to the member. The member must notify Florida Blue HMO that he/she wishes to meet with Florida Blue HMO representatives concerning the grievance or appeal.
The member has the right to submit oral or written documents, records, or other information relating to their grievance or appeal.

Florida Blue HMO will provide to the member any of the forms necessary with each written decision letter or upon request of the member. The member may obtain such forms by calling the customer service number on the ID card.

If the grievance or appeal involves an adverse benefit coverage determination for payment of a service that does not meet Florida Blue HMO's medical necessity/appropriateness criteria or the service is excluded from payment because it meets the definition of an experimental or investigational, the member may request copies of the scientific or clinical criteria utilized in making the adverse benefit coverage determination.

For reconsiderations involving adverse benefit coverage determinations Florida Blue HMO will appoint a physician(s) not involved in the initial review process to review the grievance/appeal. The appointed physician(s) will not be the individual who made the initial adverse determination nor be a subordinate of such individual.

Florida Blue HMO will resolve a member's grievance/appeal within 30 calendar days of receipt of the grievance or appeal for a pre-service claim, within 60 calendar days of receipt of the grievance or appeal for a post-service claim and within 72 hours for a grievance or appeal involving urgent care.

**Florida Blue HMO Member Grievance and Appeals**

Florida Blue HMO has established a process for reviewing member complaints and grievance or appeals. The purpose of this process is to facilitate review of, among other things, a member's dissatisfaction with Florida Blue HMO, its administrative practices, benefit coverage and payment determinations, or with the administrative practices and/or the quality of care of any of the independent contracting health care providers in the Florida Blue HMO provider network. The Florida Blue HMO Grievance and Appeal Process also permit a member, or his/her physician, to expedite Florida Blue’s review of certain types of complaints or grievance or appeals. Members must follow the process set forth below in the event of a complaint, grievance or appeal. All references to "member” also include a member’s authorized representative.

A member, or a provider acting on behalf of the member, may submit a grievance or appeal. To submit or pursue a grievance or appeal on behalf of a member, a health care provider must previously have been directly involved in the treatment or diagnosis of the member.

The member or a provider acting on behalf of a member may call Florida Blue at the number listed on the ID card or at (877) 352-2583. Hearing and speech impaired members may contact Florida Blue by dialing (800) 955-8771 via TTY.

**Grievances and Appeals Address**

Florida Blue HMO  
PO Box 41609  
Jacksonville, FL 32203-1609  
Attn: HMO Member Appeals & Disputes
**Member Standard Appeals**

The attending physician, if authorized to do so by the member, may act on behalf of the member to request a standard review of an adverse benefit determination made by Florida Blue.

If, after review of the clinical information received, the Florida Blue Medical Director does not approve benefit coverage for payment of the service(s) requested, the member and member's physician will be notified in writing of the adverse benefit coverage determination and the member’s right to appeal or grieve the determination.

All Florida Blue treating physicians have the opportunity to discuss any adverse benefit coverage determination based on medical necessity/appropriateness with the Medical Director who made the decision. In the written notification an explanation of this procedure is included within each adverse benefit coverage notification.

Providers and/or members may request a review of the supporting clinical criteria utilized in the benefit coverage decision-making process for determining benefit coverage for payment of services based on medical necessity/appropriateness. If you would like to review the clinical criteria used, contact the UM department.

**Member Pre-Service Appeals**

A physician shall use the member appeal form for pre-service appeals. If they are appealing on behalf of a Florida Blue member, except for urgent pre-service Appeals, authorization must be obtained from the Florida Blue member in writing. Pre-service appeals will be handled by Florida Blue under the appeal process available to its member based on the terms of that member’s contract or policy and the applicable state and federal laws and regulations.

**Expedited Review of Urgent Complaints, Grievances or Appeals**

If Florida Blue or Florida Blue HMO, based on information received, makes an adverse benefit coverage determination that a service, which has not yet been provided to the member is not a covered benefit for payment purposes or is specifically limited or excluded from benefit coverage under the terms of the member's handbook, the member, or a provider acting on behalf of the member, may submit a verbal (i.e., non-written) or written request for expedited review.

A member, or a provider acting on behalf of the member, may request expedited review if a delay in making a benefit coverage determination by applying the standard timeframes of the grievance and appeal process would seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, or in the opinion of a physician with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
Member Process for Requesting an Expedited Review

The member, or a provider acting on the member's behalf, must specifically request an expedited review. For example, the expedited review may be requested by stating verbally or in writing: "I want an expedited review." Only those services that have not yet been provided, i.e., pre-service claims or requests for extension of concurrent care services made within 24 hours prior to the termination of authorization for such services, are subject to this expedited review process.

Information necessary to evaluate an expedited review may be transmitted by telephone, fax, or such other expeditious method as is appropriate under the circumstances.

Generally, we will make a decision and notify the member and the provider acting on behalf of the member, within 72 hours after receipt of the request for expedited review.

If a member's request for expedited review arises out of a utilization review determination by us that a continued hospitalization or continuation of a course of treatment is not medically necessary/appropriate, benefit coverage for the hospitalization or course of treatment will continue until the member has been notified of the final benefit coverage determination.

We will provide written confirmation of its benefit coverage determination concerning an expedited review within two working days or three calendar days whichever is less after providing the initial notification of that decision, if the initial notification was not in writing.

We will not honor a request for expedited review that relates to services that have already been provided to or received by the member. Members must submit any such dissatisfaction or dispute to us in accordance with the standard grievance and appeal process.
Member Medicare Appeals

Who May File an Appeal, Grievance, or Complaint?

A member may file an appeal, grievance or complaint or may appoint an individual as a representative to act on his or her behalf by submitting to Florida Blue their name, original Medicare number, and a statement or appointment of representative form, which appoints an individual to act as their representative.

Note: A member may appoint a physician or provider to act as their representative. The statement must be signed and dated by the member and the appointed representative unless the representative is an attorney. The signed statement must be included with their appeal.

A member has the right to make a complaint if they have concerns or problems related to coverage or care. Appeals and grievances are the two different types of complaints a member can make, depending on the situation. If a member makes a complaint, we must treat the member fairly and not discriminate against him or her because of the complaint. A member also has the right to get an informational summary about past appeals and grievances that other members have filed against Florida Blue in its capacity as a Medicare Advantage (MA) organization.

The member is financially responsible for any rendered service deemed not medically necessary as a result of the Voluntary Predetermination for Select Services (VPSS) review process.

Members have appeal rights in the event of an adverse pre-service benefit determination:

- A member, or provider on behalf of a member, has the right to a pre-service benefit determination. In the event of an adverse determination, the provider may submit an appeal on a member’s behalf by obtaining written permission from the member by completing the Member Appeals Appointment of Representation Form. The member or provider should also complete the Medicare Advantage Grievance and Appeal Form and submit the forms to Florida Blue. Both forms can be accessed from the member website at www.BlueMedicareFL.com
**Appeals for Medicare Advantage Non-Par Providers**

Providers not participating with a particular Florida Blue Medicare Advantage plan have the right to appeal. You may file your appeal in writing within 60 calendar days after the date of the remittance advice. To obtain the Non-Participating Medicare Advantage Appeal form, click here. The time can be extended if you can provide evidence for what prevented you from meeting the deadline. For us to review your appeal, we will need your completed signed Waiver of Liability Statement. To obtain a Waiver of Liability form, click here. Upon review of this Appeal form and the Waiver of Liability form, we will give you a decision on your appeal within 60 calendar days.

Physicians and suppliers who have executed a waiver of beneficiary liability are not required to complete the CMS-1696, Appointment of Representative, form. In this case, the physician or supplier is not representing the beneficiary, and this does not need a written appointment of representation. If the Medicare health plan does not receive the form/documentation by the conclusion of the appeal time frame, the Medicare health plan should dismiss the appeal.

If you appeal, we will review our initial decision. If payment for any of your claims is still denied, we will forward your appeal to the Centers for Medicare & Medicaid Services Independent Review Entity (IRE) for a new and impartial review. If the IRE upholds our decision, you will be provided with further appeal rights as appropriate.

**Medicare Expedited 72-Hour Determination and Appeal Procedures**

A member may request and receive expedited decisions affecting his or her medical treatment in time-sensitive situations. A time-sensitive situation is a situation where waiting for a decision to be made within the time frame of the standard decision-making process could seriously jeopardize the member’s life or health or ability to regain maximum function. If Florida Blue decides, based on medical criteria, that the member’s situation is time-sensitive or if any provider makes a request for the member by writing or calling in support of the member’s request for an expedited review, we will issue a decision as expeditiously as the member’s condition requires, but no later than 72 hours after receiving the request.

Florida Blue may extend this time frame by up to 14 calendar days if a member requests the extension or if we need additional information and the extension of time benefits the member. For example, Florida Blue may need additional medical records from non-contracting providers that could change a denial decision. A decision will be made as expeditiously as the member’s health requires, but no later than the end of any extension period.

An expedited reconsideration may not be a request for payment.
Original Adverse Organization Determination Overturned:

If the expedited reconsideration determination is completely favorable to the member, Florida Blue notifies the member within 3 calendar days and mails a written confirmation letter. An extension of up to 14 calendar days is permitted for a 72-hour appeal, if the provider or the member asks for the extension, or if we need more information and the extension of time benefits the member; for example, if a provider needs time to provide us with additional information.

Original Adverse Organization Determination Upheld:

If Florida Blue decides to uphold the original adverse decision either in whole or in part, the entire case will be forwarded by Florida Blue to Maximum Federal Services, the independent entity contracted by CMS, for review as expeditiously as the member’s health condition requires, but no later than 24 hours after our decision. Maximus Federal Services will send the member a letter with their decision within 72 hours after they receive the member’s case from us, or at the end of up to a 14 calendar day extension.

- If Maximus Federal Services decides in the member’s favor and reverses our decision, we must authorize the service under dispute as expeditiously as the member’s health condition requires but no later than 72 hours from the date Florida Blue receives Maximus Federal Services’ notice reversing our decision.
- If Maximus Federal Services does not fully rule in favor of the member, there are further levels of appeal as discussed above.

You may mail your written appeal to:

Florida Blue
Medicare Advantage Appeals
P.O. Box 41609
Jacksonville Florida 32203-1609

Written appeal address

Florida Blue
Grievance & Appeal Dept.
8400 NW 33rd St
Miami, Florida 33122

Contact Information

1-800-926-6565
8:00 a.m. – 9:00 p.m. ET

To file a grievance or appeal on a MA member’s behalf, send to:

Florida Blue
Medicare Advantage Appeals Department
P.O. Box 41609
Jacksonville, FL 32203-1609
Member Grievance

Grievance refers to any member complaint or dispute other than one involving an organization determination as described under the appeal section. Examples are waiting times and provider behavior, adequacy of facilities, formulary and/or its administration, the quality of service received and other similar member concerns.

Under the Florida Blue grievance process a member may bring his/her dissatisfaction to Florida Blue’s attention either informally or formally. Florida Blue encourages members to first attempt informal resolution of any dissatisfaction by calling Florida Blue. If Florida Blue is unable to resolve the matter on an informal basis, members may submit their formal request for review in writing.

Informal Review (Complaint)

To advise Florida Blue of a complaint, the member should contact a Florida Blue member services representative at the local Florida Blue office, either by telephone or in person. The member services representative working with appropriate personnel will review the member’s complaint within 30 calendar days of its receipt and attempt to resolve it to the member’s satisfaction. Florida Blue may extend this timeframe by up to 14 calendar days if the member requests the extension or if Florida Blue believes that requesting additional information might be helpful to the member. If the member remains dissatisfied with Florida Blue’s resolution of the complaint, the member may request a formal review in accordance with the formal review information below.

Formal Review (Grievance)

While a member is not required to use a Florida Blue Grievance Form, Florida Blue strongly urges a member to submit his/her grievance on such a form. Forms may be obtained by calling the customer service number listed on the ID card. Upon request, member services representatives will assist the member in preparing the grievance. Hearing and speech impaired members may contact Florida Blue by dialing the Florida Relay number 711 via TTY.

Florida Blue will review the grievance in accordance with the standard grievance process and advise the member of its decision in writing. Review by Florida Blue will take no longer than 30 calendar days from receipt of the member’s grievance. Florida Blue may extend this timeframe up to 14 calendar days if the member requests the extension or Florida Blue believes that requesting additional information might be helpful to the member.
**Expedited Grievances**

Member grievances are handled as expeditiously as the situation warrants; however there are three situations where the member has the right to file an expedited grievance. Florida Blue must respond to the member within 24 hours when the member requests an expedited grievance in the following situations:

- Florida Blue advises the member that their request for an expedited organization determination does not meet criteria, and instead applies the standard timeframe.
- Florida Blue advises the member that their request for an expedited appeal does not meet criteria and instead applies the standard timeframe/reconsideration process.
- Florida Blue grants an extension for up to 14-days for an expedited or standard organization determination or appeal and the member disagrees with Florida Blue’s decision to grant an extension.

**How to Request an Expedited 72 Hour Review**

An expedited review can be requested by the member, his or her representative or a provider acting on behalf of the member (a provider does not have to be an appointed representative to request an expedited reconsideration on behalf of the member) by submitting an oral or written request directly to Florida Blue. If the request is from the member, Florida Blue must provide an expedited reconsideration if Florida Blue determines that applying the standard reconsideration time frames would seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.

If Florida Blue denies a request for an expedited reconsideration, the request becomes a standard reconsideration subject to the 30 calendar-day time frame. Florida Blue promptly notifies the member verbally within 72 hours by telephone or in person. Florida Blue sends a written letter within 3 calendar days of the oral notification explaining that the request will be processed using the 30-day standard reconsideration time frame. The letter informs the member of the right to file an expedited grievance if the member disagrees with a decision not to expedite. Instructions about the grievance process and time frames are also included.

If a request is made by or supported by a provider, Florida Blue must provide an expedited reconsideration if the provider indicates that applying the standard reconsideration time frames would seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.

The provider should specifically request an expedited review. If Florida Blue upholds its initial determination it must forward the member’s case file to the independent review entity as expeditiously as the member’s health requires, but no later than within 24 hours of affirmation of its adverse organization determination.
Compliance & Programs

Quality Programs

Physician and Provider contracts require participation in our Quality Improvement Programs. As part of our Quality Improvement Programs we may utilize information such as claims, encounter data and/or medical record data to improve the health care of its members.

Florida Blue’s QI Programs include; but are not limited to, the following:

- Medicare Stars Program
- Clinical Practice Guideline Monitoring and Improvement
- Condition-Specific Interventions and Programs
- Credentialing/Re-credentialing
- Delegated Quality Management
- Diagnostic Imaging Quality Assessment Program
- Financial Incentives Policy for UM Programs
- Incident Reporting Member and Provider Satisfaction Assessment
- Preventive Health Monitoring and Improvement
- Quality Performance Indicators
- Quality Programs Combined
- Utilization and Over-Utilization Assessment

Medicare Stars Program

The Centers for Medicare and Medicaid Services (CMS) is working with Medicare Advantage Plans like Florida Blue to improve the quality and cost effectiveness of services provided to beneficiaries. The Medicare STARS rating program measures how well plans perform based on a cross section of quality metrics including clinical, pharmacy, member satisfaction with their plan (as well as providers), health outcomes and plan operations. The 50+ metrics are divided into the following categories:

- Category 1: Staying healthy Evaluates how often members receive screening tests, vaccines, checkups and other preventive services to help them stay healthy.
- Category 2: Managing chronic conditions Evaluates how effectively health plans help members manage long-term conditions, with a focus on diabetes and medication management.
- Category 3: Member satisfaction Evaluates member satisfaction with their health plan and how they feel about the quality of care they receive from the health plan and providers.
- Category 4: Customer service Evaluates how responsive and helpful the plan’s customer service is and the accuracy of information given to members.
A Plan’s star ratings are ranked 1-5 in each category, then used to determine the plan’s overall score:

- ***** Excellent performance (Green Stars)
- **** Above average performance (Maroon Stars)
- *** Average performance (Orange Stars)
- ** Below average performance (Purple Stars)
- Poor performance (Red Star)

Our goal is to help our members maintain and improve their health outcomes and effectively manage long-term conditions.

We continue to work with Care Management Healthcare Quality, and our network providers, to help our members stay healthy by evaluating how often members receive screenings, vaccines, checkups and other preventive services.

Florida Blue has a dedicated team focused on improving our star ratings for the measures that have not achieved the highest possible scores. Our overall goal is to improve the health of our members, attract new members to our high quality plans and continue offering competitive reimbursement to our providers. Florida Blue continually evaluates the star ratings and the individual measures that comprise them.

We encourage our providers to continue to provide stellar services to our members. You help impact our star ratings by:

- Making sure your patients receive routine screening test and preventive services.
- Helping patients manage their chronic conditions, such as high blood pressure, arthritis and diabetes. This is reflected in our star ratings for category 2.
- Helping patients choose safe medications. High Risk Medication (HRM) alternative list
- Ensuring patients are continually taking their medications (particularly oral diabetic, cholesterol, HTN ACE/ARB).
- Submitting claims and documenting all services thoroughly and accurately. Risk Adjustment Information
- Understanding the impact that you and your office staff have on your patients’ (our members’) satisfaction with their health experience, which is reflected in CAHPS and HOS surveys.

Please see our HEDIS® and Stars Documentation and Coding Guide for an in-depth view of how you can help our members maintain and improve their health outcomes. You can also find this Guide on our website, just select the Providers tab, click on Tools & Resources and then click on Medicare Stars / HEDIS / CHAPS.
Clinical Practice Guideline Monitoring and Improvement

Clinical practice guidelines are used to assist practitioners and members in their decisions about appropriate care for specific clinical circumstances. Florida Blue uses national, state, or specialty recognized guidelines. Local physician committees have opportunities to advise on the use of these guidelines.

Some of the clinical practice guidelines used by Florida Blue include:

- The American Diabetes Association - Adult Diabetes
- The National Institute of Health - Asthma (Pediatric And Adult)
- The American College of Cardiology – Heart Failure, Coronary Artery Disease
- The Journal of the American Medical Association – Hypertension
- The American Psychiatric Association - Major Depression
- The Global Initiative for Chronic Obstructive Lung Disease – Chronic Obstructive Lung Disease
- National Institute of Mental Health – Bipolar Practice Guidelines

We select several key indicators from at least two of these clinical practice guidelines to monitor the process and outcomes of care related to these practice guidelines. This may require periodic review of the participating physician’s office record.

Clinical practice guidelines are periodically reviewed and evaluated for updates and changes. Practice Guidelines are available on our website under Medical Information.

Condition Specific Interventions and Programs

Condition-specific interventions and programs focus on improvement of specific clinical conditions and promote continuous quality improvement for our members. Providers are encouraged to collaborate with us in an effort to close gaps in clinical care. This can be accomplished by referring members with chronic conditions into our Clinical Operations Programs, where they will receive condition specific coaching and education related to their condition.

Financial Incentives Policy for Utilization Management Programs

Our policy on financial incentives for Utilization Management (UM) programs applies to practitioners, providers, and employees involved in, or those who supervise those involved in making coverage and benefit UM decisions. Our policy on financial incentives is as follows:

- Utilization Management decision-making is based on the factors set forth in our definition of medical necessity for coverage and payment purposes in accordance with Medical Policy Guidelines, then in effect, and the existence of coverage and benefits under a particular contract, policy or certificate of coverage. We are solely responsible for determining whether expenses incurred, or to be incurred, or whether medical care is, or would be, covered or paid under a contract or policy. In fulfilling this responsibility, we shall not participate in or override the medical decisions of any physician or provider.
- Our payment policies are not designed to reward practitioners or other individuals conducting UM for issuing denials of coverage or benefits.
- Financial incentives for UM decision makers are not designed to encourage decisions that result in underutilization. Rather, the intent is to minimize payment for unnecessary or inappropriate health care services, reduce waste in the application of medical resources, and minimize inefficiencies, which may lead to the artificial inflation of health care costs.
Incident Reporting

Florida Blue (Blue Cross and Blue Shield of Florida, Inc.) and its affiliate, Florida Blue HMO (Health Options, Inc.) and BlueMedicare HMO/PPO complies with incident reporting as defined in the Florida Administrative Code (F.S. 59A-12.012(4),F.A.C.) and requires provider assistance in obtaining the information to be reported.

The state defines the type of incidents that must be reported as, “an event over which health care personnel could exercise control,” and:

- Is associated in whole or in part with medical intervention rather than the condition for which such intervention occurred, and
- Is not consistent with or expected to be a consequence of such medical intervention; or
- Occurs as a result of medical intervention to which the patient has not given his informed consent; or
- Occurs as the result of any other action or lack thereof on the part of the facility or personnel of the facility; or
- Results in a surgical procedure being performed on the wrong patient; or
- Results in a surgical procedure unrelated to the patient’s diagnosis or medical needs being performed on any patient including the surgical repair of injuries or damage resulting from the planned surgical procedure, wrong site or wrong procedure surgeries and procedures to remove foreign objects remaining from surgical procedures; and
- Causes injury to the patient.

Report such incidents to the Provider Contact Center and request an incident report be submitted to the Quality Management Department.

Member and Provider Satisfaction Assessment

- Satisfaction surveys are a critical component of quality improvement.
- Surveys are conducted in order to obtain the member’s perspective of the quality of care and service received.
- Feedback is provided to primary care physicians.
- Providers are surveyed to gain an understanding of their level of satisfaction with the quality of services provided by various departments within Florida Blue.
- Information is provided to members and providers via newsletters.

Comprehensive Quality & Risk Program (CQRP)

The Comprehensive Quality & Risk Program (CQRP) focuses on identified members who may have clinical and quality of care opportunities. The Comprehensive Quality & Risk Program is designed to bring the member and their physician together to holistically evaluate the member’s health condition, lifestyle and overall well-being, assess medications prescribed, facilitate the management of persistent or chronic conditions, and identify and close preventive care gaps.

- Clinically-driven algorithms look back through two years of administrative and claims data to identify members who have chronic conditions and clinical and quality of care opportunities.
• Each identified member will have an associated Comprehensive Quality & Risk Health Assessment Form in Availity®1 Payer Spaces Work Queue.
• The Panel Roster in Availity®1 Payer Spaces delivers a view of the patient population with a health assessment form at the individual physician level within a provider group and physicians will receive email notifications indicating any updates to the panel roster.
• Physicians should contact their patients to schedule an appointment for an annual comprehensive health assessment.
• A comprehensive health assessment must be performed with the patient and the practitioner must fully complete, electronically sign the Comprehensive Quality & Risk Health Assessment Form with his/her credentials and submit through Availity®1. Providers must also submit a claim to Florida Blue with applicable CPT, diagnosis and/or HCPCS codes for the comprehensive visit performed.

Preventive Health Monitoring and Improvement

The Preventive Health Monitoring and Improvement program promotes the appropriate use of preventive health services for members in order to positively impact personal health behaviors and medical outcomes. Program monitoring in the form of focused studies may require periodic review of the participating physician’s office records.

Florida Blue has adopted the USPSTF Preventive Services Guidelines, which are available on our website under Medical Information.

Quality Performance Indicators

Performance measures have been selected for the purpose of assessing certain “process of care” and/or “outcome of care” dimensions for each important aspect of care and service.

• Measures serve as indicators to both consumers and the public in evaluating how well the Florida Blue health care delivery system is meeting customer needs in these areas.
• Measures can also be used by health care providers to evaluate and improve care and service to members.
• The performance measures were developed through review of work conducted by leaders in the field of health care quality improvement.
• Currently we report both HEDIS and CAHPS data sets.

Under-Utilization and Over-Utilization Assessment

• CMS requires Medicare Advantage plans to facilitate delivery of appropriate care and monitor the impact of its UM programs to detect and correct potential under/over utilization of services. MA health plans using physician incentive plans that place a physician or physician group at substantial financial risk (as defined at 42 CFR 422.208(d) should review utilization data to identify patterns of possible underutilization of services that may be related to the incentive plan.
• Under-utilization of services may exist when medical services vary substantially when physicians are compared to a peer group, or services are not provided according to the level specified in practice parameters, industry standards, or other benchmarks.
• Under and over utilization assessment is applicable to Florida Blue’s HMO (Commercial and Medicare) products.
• We use several mechanisms to monitor under and over use of services.
Quality Improvement Organizations (QIOs) are organizations comprised of practicing doctors and other health care experts under independent contract by the Centers for Medicare and Medicaid Services (CMS) to review the medical necessity, appropriateness and quality of medical care and services provided to original Medicare and MA beneficiaries by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, comprehensive outpatient rehabilitation facilities, Medicare managed care plans, and ambulatory surgical centers.

Note: KEPRO is the independent reviewer (QIO) authorized by CMS to perform these reviews.

QIO Review of a Member’s Hospital Discharge Appeal

When a member is admitted to an acute care hospital to receive care, upon discharge he or she may believe they are being asked to leave the hospital too soon. If the member disagrees with the discharge decision, the member will receive the NODMAR which outlines the process for the member to appeal the decision to the QIO. A member will also receive the NODMAR when being discharged (transferred) to a lower level of care within the same acute care facility and he or she may appeal this decision. The member has until noon of the next working day to appeal the determination by requesting an immediate QIO review. During this review, the member may remain in the hospital with no additional financial liability.

The hospital and/or MA Organization must submit medical records and other pertinent information to the QIO by close of business of the first full working day immediately following the day the request for this information was made.

As part of the review, the QIO must solicit the views of the member and may contact the attending physician. The attending physician of record will be contacted by telephone by the QIO’s physician advisor assigned to the review. The attending physician should be cooperative and candidly express their opinion as it pertains to the member’s continued hospital stay. The QIO must notify the member, the hospital and the MA organization of its determination within one full working day after it receives all necessary information from the hospital and/or the MA organization.

If the member wishes to appeal the discharge decision, but does not do so within the time frames noted above, he or she may request an expedited reconsideration by the MA organization.

Note: “Member” as used in this section includes a member’s representative.

QIO Review of Members’ SNF, Home Health Care, and Comprehensive Outpatient Rehabilitation Facility Discharge Appeal

Members of MA plans who are receiving authorized, covered services from SNFs, home health agencies, or comprehensive rehabilitation facilities are afforded the opportunity to appeal the termination of coverage by requesting an expedited reconsideration by the QIO or through Florida Blue’s expedited appeal process if they are dissatisfied with the decision to terminate coverage. Members will receive written notices regarding the termination of coverage and the appeal process. Termination of coverage can result from either of the following activities:

- Attending physician discharges the member from the services being received; or
- Florida Blue, in conducting concurrent care reviews, determines that the member no longer meets criteria to continue coverage for the services being rendered.
QIO Review of Quality of Service Complaints

A member may contact the QIO at the address below if they have complaints about the quality of care they received from contracting providers including physicians, hospitals, skilled nursing facilities and home health agencies. Each complaint is investigated and reviewed by appropriate qualified clinical personnel.

KEPRO
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
Phone: (844) 455-8708
Fax: (844) 834-7129
Non-Participating Medicare Advantage Provider Appeals

Diagnostic Imaging Quality Program

The purpose of the Diagnostic Imaging Quality Program is to further our ongoing commitment to promote patient safety and quality of care in outpatient settings by ensuring our members receive services at sites where equipment, physicians, and technologists meet recognized national industry standards. The following are the objectives of the program:

- Establish a shared understanding of current quality standards for advanced imaging service (AIS) providers based on objective, quantifiable measures.
- Collaborate with AIS providers to identify areas for quality improvement and offer those providers the opportunity to address those areas.
- Implement industry standards, which demonstrate providers’ commitment to quality of care and patient safety

Advanced Imaging Service (AIS) Providers Quality Program

AIS include such services as CT scans, MRIs, Nuclear Cardiology, and PET scans whereas contracted providers including physicians and Independent Diagnostic Testing Centers (IDTCs) that render diagnostic imaging services to our members are required to participate in the Diagnostic Imaging Quality Program, which is a component of our Quality Improvement Program.

We work collaboratively with National Imaging Associates (NIA), an independent vendor, to administer the Diagnostic Imaging Quality Program. A component of our Quality Programs, accreditation through either American College of Radiology (ACR) or Inter-societal Accreditation Commission (IAC) will be a requirement for obtaining a pre-authorization or Voluntary Predetermination for Select Services (Voluntary Predetermination for Select Services) from National Imaging Associates (NIA) for all lines of business. Payment for AIS will be conditional based upon having met our Quality Programs criteria. This requirement applies to those physicians and non-hospital facilities that perform outpatient imaging studies and bill on a CMS-1500 Health Insurance Claim Form or its electronic equivalent. This includes, but is not limited to, office-based physicians and IDTCs that provide and bill for the technical or global component of advanced imaging services. This requirement does not apply to a bill submitted solely for professional services related to advanced imaging. To learn about diagnostic imaging utilization management programs, refer to the NIA section.
Accreditation can be obtained by contacting the ACR or IAC at the websites below.

- The American College of Radiology (ACR) [www.acr.org/accreditation.aspx](http://www.acr.org/accreditation.aspx)
- Inter-societal Accreditation Commission (IAC) [www.intersocietal.org/intersocietal.htm](http://www.intersocietal.org/intersocietal.htm)

Physicians may continue to provide professional services to members and refer their patients needing AIS to an IDTC that has met the quality criteria. Notify your physician contract manager if you will no longer provide these services. Your Florida Blue participation status for professional services will not be affected.

**Audit Programs**

All participating providers are required to comply with our audit programs and to cooperate and assist us in conducting audits of claims submitted. Audits are intended to determine if claims payments were accurate. If a provider fails to follow the procedures for disputing or contesting an audit finding, then we may proceed with collection of such amounts as allowed by law, including but not limited to, offsetting against other amounts due to provider.

This information is intended to serve only as a general reference resource regarding our provider audit and recovery process and is not intended to address all reimbursement situations or all processes that may be utilized.

The Healthcare Provider Audit department is responsible for identification and recovery of overpayments through audit activities for all providers. The scope of audit focuses primarily on the identification of claims overpayments and subsequent recoveries.

All claim audits are conducted on a claim-by-claim basis. Some audits review many issues concerning the claims, but others are targeted reviews related to specific issues. A typical audit may include not only a review of the claim itself but also a review of the medical records or other supporting documents to substantiate the claim submitted. Audits may be conducted by us, our customers or governmental, accreditation or regulatory agencies. Providers are required to participate in audits conducted by all such parties, including any contracted vendors utilized to conduct the audits.

Depending on specific claim reimbursement terms, audit reviews may consider, but are not limited to:

- Compliance with contractual conditions and terms
- Appropriateness of coding (e.g., national coding standards; CPT, HCPCS, ICD9-CM, others as applicable)
- Unbundling of services/procedural codes (e.g., Hospital Charge Reimbursement Definitions, Correct Coding Initiative and code editing hardware)
- Billing accuracy
- Duplicate payments
- Member benefits, exclusions and coverage periods
- Claims processing guidelines
- Criteria supporting medical appropriateness of care and/or compliance with Florida Blue’s Medical Policies (Medical Coverage Guidelines)
- Accuracy of the authorization and prior approval processes, where indicated or required
- Our payment methodologies
We may request medical records or supporting documentation in connection with an audit. If we request medical records, you will provide copies of those free of charge unless otherwise required by law or contract.

All audits will be conducted in accordance with any applicable state or federal laws or requirements along with any provisions set forth in a provider's participation agreement with us.

**In House Audits**

Certain audits do not require us to be onsite at the provider's location. Such audits are less costly and administratively burdensome for both us and the provider. Providers are required to provide us with any medical records or supporting documentation required to conduct such desk audits. Desk audits include, but are not limited to the following:

Check Run Audits - Based on the weekly check runs, individual claim payments may be audited based on specific payment parameters for each type of service (e.g., all outpatient claims over a specific dollar amount).

Claims Payment Review - Verifies payment accuracy in accordance with the provider's contract, applicable processing/coding guidelines and the member's benefits/limitations.

Targeted Audits - Systemic auditing using certain payment codes, specific contract terms, specific contract load issues, or procedures that have been identified as a concern for all or specific contracted providers.

Special Request Reviews - Review of a specific providers as requested by an account or group, our Medical Operations, Marketing, Special Investigations or other areas within the Plan for a specific purpose.

**Provider Audit Process**

**Notification/Confirmation Responsibilities:**

- Prior to a provider audit, we will provide notification of at least 10 working days prior to the audit start date via email, mail, telephone or fax.
- The notification will include, but not limited to, the following:
  - Audit type to be performed
  - If applicable, the list of claims with the member name, patient account number and dates of service
  - A request for medical documents or components to support billing
- For Onsite audits we may request a formal entrance conference with applicable provider designee and our audit staff. The formal entrance conference will take place on the first day of the onsite audit.

**Note:** Certain targeted audits are conducted without prior notification to the provider. In these instances the provider will have the opportunity to respond to the findings.
Provider Responsibilities:
We require formal acknowledgement of the notification of an audit. Acknowledgement should include:

- Contact name and telephone number for individual(s) responsible for coordinating the audit and the provider designee responsible for finalizing and approving audit findings
- For onsite audits, confirmation of the date, time and location for the entrance conference and, if applicable, medical record review
- If requested, provide facilities for the entrance and exit conference and ensure attendance by staff authorized to approve audit findings.

Our Responsibilities:

- Perform audit
- Discuss preliminary findings with the provider. Discussion and revision of the audit findings may be conducted by telephone, fax, mail or additional onsite meetings.

Provider Responsibilities during the audit, the provider agrees to:

- Provide all charts, invoices, itemized bills, financial records and other data requested to support the documentation of claims payment accuracy
- Provide copies of requested documentation, to be given to auditor or mailed to appropriate address as directed by the auditor.

Audit Findings Our Responsibilities:

- Mail a copy of the preliminary audit findings to provider designee. Discussion and revision of the audit findings may be conducted by telephone, fax, mail or additional onsite meetings.

Provider Responsibilities:

- The provider designee will review/communicate the preliminary audit findings with provider personnel authorized to finalize audit findings.
- Provide formal acceptance of each finding in anticipation of the exit process.
- When applicable, refund member copayments and correct the audited accounts to ensure no further adjustment activity occurs.

Escalation Process

Issues and concerns related to findings resulting from an audit should follow a normal course of resolution, which is resolved through:

- Prior to the issuance of the final audit findings, the assigned Florida Blue auditor will review any issues and will refer the matter to the responsible Florida Blue audit manager, if necessary.
- After the issuance of the final audit finding, if provider followed the required process to dispute or contest the audit findings, as outlined above, the matter will be referred to the appropriate resource:
  - Contractor/Negotiator
  - Medical Director
  - Legal Affairs Division
• If provider has followed the required process to dispute or contest the audit findings and internal resources are unable to resolve the matter, then either party may proceed to formal dispute resolution in accordance with provider's participating provider agreement.

Exit Process

Our Responsibilities:

An exit conference will be conducted with provider designee including an overview of audit findings. Exit conferences may be conducted via telephone if in person conference is not required.

• Discussion of overpayment recovery process: Upon completion of the audit, repayment will be requested from the provider, to be mailed to the Florida Blue Overpayment Recovery lockbox with audit summary attached (refer to Overpayment Recovery) or recoupment may be initiated by offsetting refunds due to us.

• In cases where the provider requests the use of the offset payment methodology, no checks should be sent to us. Using the offset process will significantly reduce the potential for duplicate recovery processing.

A final exit letter documenting agreed upon audit results, terms of collections for overpayment, and names of the designees present at the exit.

Vendor Audits

We may use contracted vendors to supplement audit activities when considered necessary to reduce risk and exposure to the company. Contracted vendors must follow all audit procedures when conducting audits for us. Vendor activities are centrally coordinated by the Healthcare Provider Audit department to ensure statewide consistency. In these audits, the provider will need to send the check to the address contained in the audit letter, not directly to Florida Blue. The directions indicated in the audit letter need to be followed to ensure appropriate adjustments and credits are made to the audited claim.

Medicare Advantage Onsite Compliance Audits

To comply with CMS guidelines, selected claims from Medicare Advantage providers are audited on an annual basis. The provider is responsible for ensuring the “original” records are authenticated by one of three forms—handwritten signature, signature stamp, or electronic signature. Transcribed records must have one of the above forms of authentication.

A formal entrance conference will provide the scope and purpose of the audit, arrangements for photocopying and/or scanning of medical documentation, as well as to establish the exit conference criteria.

In cases where discrepancies are noted from the audit, adjustments will be made to the diagnoses based on the medical record documentation.

We will provide information and education to provider staff and possible follow-up audits may be scheduled to ensure encounter data submission accuracy.
Specialized Audits

Specialized audits maybe performed on but not limited to the following:

- Claims payment based on charges
- Catastrophic/Trauma claim audits/claims payment based on charges –
  - Itemized bills for inpatient claims, meeting specific provider contractual limitations/conditions and Hospital Charge Profile/Charge Reimbursement definitions in conjunction with our billing guidelines.

Encounter/Claim Data Audits

Medicare Advantage providers will be randomly selected for provider audits to verify compliance with encounter/claim data submission. Providers will be notified 15 working days prior to the onsite audit. The focus of the audits will be:

- To determine based on the audit findings that the encounter/claim data audited is complete, truthful, and accurate.
- To compare reported encounter/claim data to a sample of medical records to verify the accuracy and timeliness of the reported information. The audit unit will provide the provider with written information concerning compliance and/or audit findings.

Provider Non-Compliance/Penalties

If it is determined through provider audits, or any other means, that a provider is non-compliant with encounter/claim data submission, the following steps will be taken:

- The provider will be notified in writing and we will place the provider on corrective action for 30-days. During this time we will work with the provider to obtain compliance.
- Provider compliance will be re-assessed after 30-days. If it is determined that a provider is complying with encounter/claim data submission, the provider will be removed from corrective action. However, if the provider is still non-compliant after 30-days, we may initiate termination of the Agreement.
Participating Providers Responsibility

We offer a variety of product lines to meet the health care coverage needs of our members. Each product at Florida Blue corresponds to one or more networks (provider agreements). Below are “highlights” of responsibilities generally associated with our provider agreements; this listing is not all-inclusive.

- Provide covered services to members with Florida Blue coverage.
- Do not discriminate against any member on the basis of race, color, religion, sex, national origin, age, and health status, participation in any governmental program, source of payment, marital status, sexual orientation, including gender identity or physical or mental handicap. (See additional information under ‘Importance Notice’ below.)
- Provide our members, your patients, timely care based on their health care needs as outlined in the Florida Blue Appointment Availability and Office Waiting Time Guidelines.
- Abide by and cooperate with the policies, rules, procedures, programs, activities and guidelines contained in your Agreement (which includes the most current manual).
- Accept payment, plus the member’s applicable deductible, coinsurance and/or copayment, as payment-in-full for covered services.
- Provider does not balance bill the member for any differences between the charge and the contractual allowance. The member is only responsible for any applicable deductible, coinsurance, and/or copayment and non-covered service amounts or services exceeding any benefit limitations.
- Adhere to guidelines for usage of all electronic self-service tools; see the Frequently Referenced Section.
- Comply fully with our Quality Improvement, Utilization Management program, Case Management, Disease Management and Focused Illness/Wellness, and Audit Programs.
- Adhere to Florida Blue business ethics, integrity and compliance principles and standards of conduct as outlined in Florida Blue's code of conduct, the Compass Booklet.
- Promptly notify us of claims processing payment errors.
- Maintain all records required by law regarding services rendered for the applicable period of time. Make such records and other information available to us or any appropriate government entity.
- Treat and handle all individually identifiable health information as confidential in accordance with all laws and regulations, including HIPAA-AS and HITECH requirements.
- Immediately notify us of adverse actions against license or accreditation status.
- Comply with all applicable federal, state, and local laws and regulations.
- Maintain liability insurance in the amount required by the terms of your Agreement.
- Notify us of the intent to terminate your Agreement as a participating provider within the Member timeframe specified in your Agreement.

Important Notice Regarding Final Regulations on ACA Nondiscrimination Rules (Section 1557)
Effective July 18, 2016

- The Office of Civil Rights (OCR) and the Department of Health & Human Services (HHS) issued final regulations on May 18, 2016 finalizing Section 1557 of the Affordable Care Act (ACA). The final rule prohibits “covered entities” from discriminating on the basis of race, color, national origin, sex, age and disability and provides examples, including a prohibition on categorical exclusions or limitations on all health services related to gender transition. It incorporates many long-standing civil rights and discrimination laws that have been in place for decades (including their regulations and outcomes of thousands of lawsuits). While there are multiple federal non-
discrimination laws, this final rule clarifies the prohibition of discrimination in the health care and benefits setting. The rules apply to any carrier, employer sponsored plan, or provider who receives federal financial assistance or funding from HHS and carriers who participate in the Federally-Facilitated Marketplace, Medicare Advantage, or Medicaid.

- Providers should post notices of nondiscrimination and taglines that alert individuals with limited English proficiency to the availability of language assistance services.
  - Providers should post taglines in the top 15 languages spoken by individuals with limited English proficiency in that state and indicate the availability of language assistance. Translated Resources are available on the Health & Human Services website (https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html).
  - Providers should take appropriate steps to ensure that communications with individuals with disabilities are as effective as communication with others.
  - Providers should provide appropriate auxiliary aids and services, such as alternative formats and sign language interpreters, where necessary for effective communication.

**Discharge from PCP Practice (HMO and BlueMedicare HMO only)**

When the discharge of a BlueMedicare HMO member takes place, the following steps need to occur:

- Document 2 member letters have been sent via certified mail.
  - 1st letter: Warning to member advising of 60 notice to change behavior
  - 2nd letter: 2nd Warning to member and copy plan.
- Document reason(s) for the discharge as well as resolution attempts in the member medical record.
- Complete the Member Discharge form located at www.floridablue.com and fax to Florida Blue with copies of the member letters
- Upon receipt of the Member Discharge form, Florida Blue will:
  - Review information received for discharge approval/denial
  - Notify the provider of the decision outcome
  - Review the member PCP assignment and reassign as appropriate

When the discharge of an HMO member takes place, the following steps needs to occur:

- Complete the Member Discharge form located at www.floridablue.com, or send letter on letterhead signed by provider and fax to Florida Blue with a copy of the letter sent to the member.
- Upon receipt of the Member Discharge form, Florida Blue will:
  - Review information received for discharge approval/denial
  - Notify the provider of the decision outcome
  - Review the member PCP assignment and reassign as appropriate

**If the Agreement is terminated:**

- Continue to provide services to members who are receiving inpatient services until they are appropriately discharged and/or the specific episode of care is completed.
- Accept payment at rates in effect under the Agreement immediately prior to termination.
Member Rights and Responsibilities

- To be provided with information about Florida Blue, our services, coverage and benefits, the contracting practitioners and providers delivering care, and members’ rights and responsibilities.
- To receive medical care and treatment from contracting providers who have met our credentialing standards.
- To expect health care providers who contract with us to:
  - Discuss appropriate or medically necessary treatment options for a member's condition, regardless of cost or benefit coverage;
  - Permit a member to participate in the major decisions about his or her health care, consistent with legal, ethical and relevant patient-provider relationship requirements.
  - Advise whether a member’s medical care or treatment is part of a research experiment, and to give a member the opportunity to refuse any experimental treatments; and
  - Inform a member about any medications he or she is told to take, how to take them, and their possible side effects.
- A member has the right to receive emergency care that a member, as prudent layperson acting reasonably, would have believed that an emergency medical condition existed. Payment will not be withheld in cases when, acting reasonably, a member seeks emergency medical services.
- A member has the right to receive urgently needed services when traveling outside the service area or in the service area when unusual or extenuating circumstances prevent a member from obtaining care from an in-network provider.
- Become familiar with coverage and the rules that must be followed to get care as a member.
- Attempt to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Give doctors and other providers the information they need to provide care; and to follow the treatment plans and instructions for care that they have agreed upon.
- Act in a way that supports the care given to other patients and helps the smooth running of the doctor’s office, hospitals, and other offices and not be disruptive.
- Pay plan premiums and any copayments, deductibles and applicable coinsurance owed for the covered services received. A member must also meet other financial responsibilities that are described in the Member Handbook.
- Follow established processes for filing an appeal or grievance concerning medical or administrative decisions that he or she feels are in error
- To expect courteous service from Heath Options and considerate care from contracting providers with respect and concern for a member’s dignity and privacy.
- To voice his or her complaints and or appeal unfavorable medical or administrative decisions by following the established appeal or grievance procedures found in the Member Handbook or other procedures adopted by Florida Blue for such purposes.
- To inform contracting providers that he or she refuses treatment, and to expect to have such providers honor his or her decision if he or she chooses to accept the responsibility and the consequences of such a decision. Members are encouraged (but not required) to:
  - Complete an advance directive, such as a living will and provide it to the contracting plan providers; and
  - Have someone help make decisions, to give another person the legal responsibility to make decisions about medical care on a member’s behalf.
• To have access to your records and to have confidentiality of your medical records maintained in accordance with applicable law.
• To call or write to us any time with helpful comments, questions and observations whether concerning something you like about our plan or something you feel is a problem area. You also may make recommendations regarding Florida Blue members’ rights and responsibilities policies. Please call the number or write to us at the address on your membership card.
• (BlueCare/HMO only) Seek all non-emergency care through his or her assigned PCP, or through a contracting physician and to cooperate with all persons providing care and treatment.
• Be respectful of the rights, property, comfort, environment and privacy of other individuals and not be disruptive.
• Take responsibility for understanding his or her health problems and participate in developing mutually agreed upon treatment goals, to the extent possible, then following the plans and instructions for care that are agreed upon with a member’s Florida Blue provider.
• Provide accurate and complete information concerning a member’s health problems and medical history and answer all questions truthfully and completely.
• Be financially responsible for any copayments and non-covered services, and to provide current information concerning enrollment status to any Florida Blue-affiliated provider.
• Follow established procedures for filing a grievance concerning medical or administrative decisions that he or she feels are in error.
• Request his or her medical records in accordance with Florida Blue rules and procedures and applicable law.
• Review information regarding covered services, policies and procedures as stated in the Member Handbook.
Member Rights under BlueMedicare HMO, BlueMedicare Select and BlueMedicare Choice Products

1. Right to be treated with fairness and respect
   a. A member has the right to be treated with dignity, respect, and fairness at all times. We do not discriminate against members based on race, sex, color, ethnicity, national origin, religion, sexual orientation, gender identity or expression, age, mental or physical disability, veteran status, marital status, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

2. Right to access medical records
   a. A member has the right to access medical records and get a copy of those records. Federal and state laws protect the privacy of a member’s medical records and personal health information. Florida Blue keeps member personal health information private as protected under these laws, and makes sure that unauthorized people do not see or change a member’s records. Generally Florida Blue must get written permission from a member before we can give a member’s health information to anyone who is not providing care or paying for care. A member has the right to ask providers to make additions or corrections to medical records. If a member asks providers to do this, providers will review a member’s request and decide whether the changes are appropriate. A member has the right to know how health information has been given out and used for non-routine purposes.

3. Right to see in-network and out-of-network providers and obtain covered services within a reasonable amount of time
   a. A member has the right to choose a provider for care. A member has the right to timely access to providers and to see specialists when care from a specialist is needed. Timely access means a member can get appointments and services within a reasonable amount of time.

4. Right to know treatment choices and participate in decisions about health care
   a. A member has the right to get full information from providers when going for medical care, and the right to participate fully in decisions about health care. Providers must explain things in a way that a member can understand. Rights include knowing about all of the treatment choices that are recommended for the condition, no matter what they cost or whether they are covered under BlueMedicare HMO, PPO, or Regional PPO (RPPO). A member has the right to be told about any risks involved in care. A member must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.
   b. A member has the right to receive a detailed explanation from Florida Blue if a member believes that a plan provider has denied care that a member believes he or she is entitled to receive or care a member believes he or she should continue to receive. In these cases a member must request an initial decision.
   c. A member has the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if the doctor advises a member not to leave. If a member refuses treatment, a member accepts responsibility for what happens as a result of refusing treatment.
5. Right to use advance directives (such as a living will or a power of attorney)
   a. A member has the right to ask someone such as a family member or friend to help with decisions about his or her health care. If a member chooses, he or she can use a special form to give someone the legal authority to make these decisions.

6. Right to make complaints
   a. A member has the right to make a complaint if a member has concerns or problems related to coverage or care. Appeals and grievances are the two different types of complaints a member can make that depend on the situation. If a member makes a complaint, Florida Blue must treat a member fairly, and not discriminate against him or her because of the complaint. A member has the right to get a summary about the appeals and grievances that other members have filed in the past against Florida Blue in its capacity as a Medicare Advantage organization.

7. Right to get information about health care coverage and costs
   a. A member’s "Summary of Benefits" and "Evidence of Coverage" explain what medical services are covered as a plan member and what a member has to pay. A member has the right to an explanation from Florida Blue about any bills for services not covered by Florida Blue. Florida Blue must tell a member in writing why Florida Blue will not pay for or allow a member to get a service and how to file an appeal to ask for the decision to be changed.

8. Right to get information about Florida Blue, BlueMedicare plans, and in-network providers
   a. A member has the right to get information from us about Florida Blue and about BlueMedicare HMO, BlueMedicare Select or BlueMedicare Choice. This includes information about our financial condition, about health care providers and their qualifications, and about how BlueMedicare plans compare to other health plans. A member has the right to find out how Florida Blue pays in-network providers. Members may contact us any time with helpful comments, recommendations and/or questions about our members’ rights and responsibilities policies. Florida Blue has free language interpreter services available to answer questions from non-English speaking members.

9. Right to receive emergency care and urgently needed services
   a. A member has the right to receive emergency care that a member, as prudent layperson acting reasonably, would have believed that an emergency medical condition existed. Payment will not be withheld in cases when, acting reasonably, a member seeks emergency medical services.
   b. A member has the right to receive urgently needed services when traveling outside the service area or in the service area when unusual or extenuating circumstances prevent a member from obtaining care from an in-network provider.
**Confidentiality of Member Information**

All health care professionals who have access to medical records have a legal and ethical obligation to protect the confidentiality of member information. In order to fulfill these obligations, the following guidelines have been developed:

- By Federal Statute, all individuals and institutions with access to PHI must comply with the HIPAA Privacy Final Rule.
- All health care professionals and employed staff who have access to member records or confidential member information should be made aware of their legal, ethical and moral obligation regarding member confidentiality and may be required to sign a document to that effect.
- Member records should be accessed only by authorized staff; should not be left in public view and should be stored in an organized and consistent manner.
- Members have the right to access their medical records according to Florida Blue’s rules and in accordance with applicable law.
- Any and all discussions relating to confidential member information by staff should be confidential and conducted in an area separate from member treatment or waiting areas.
- Safeguards to maintain the confidentiality of faxed medical information should be in place.
- Primary and specialty physicians and their staff are to receive periodic training regarding protection of confidentiality of patient records and the release of records.
- In the event member records are to be sent to another provider, a copy of the signed authorization for the release of information should be enclosed with the records to be sent. The records should be sent in an envelope marked “Confidential”.

A copy of the policy on confidentiality of medical records may be posted in the provider’s office.