Florida Blue

In the pursuit of health®

Manual for Physicians and Providers

Self Service Tools

Section

Self Service

Electronic self-service tools for providers are available through the Availity and our website. The tools and forms available on these sites can help providers reduce administrative costs, improve office workflows, and assist in the collection of claim payments. Checking Availity each time will ensure you receive the most recent member information.

Providers should always utilize self-service tools prior to contacting us. We have created a new fast path priority service process, using an Availity transaction ID (fast path code), to encourage providers to use Availity before calling the Provider Contact Center for benefit information. If you need to call the Provider Contact Center and do not use an Availity transaction ID (fast path code), you will experience longer wait times.   We ask that providers adhere to guidelines for usage of all electronic self-service tools.

Electronic Capability and Participation

Providers and/or their designees (billing services, clearing houses, etc.) are required to use clinical, financial and administrative electronic self-service capabilities including those accessed through Availity. These capabilities include but are not limited to:

- Submitting administrative inquiries electronically through Availity using Authorizations and Referrals Review and Inquiry, Eligibility and Benefits, CareCalc, Claim Reconciliation Tool and Claims Status.
- When utilizing certain Availity transactions (Authorizations and Referrals Review and Inquiry, Eligibility and Benefits Inquiry) providers should use the automated transaction and obtain an Availity transaction ID by accessing Availity. This transaction ID will provide fast path priority service if you should need to call us for assistance. Providers will not receive eligibility and benefits information without a transaction ID.
- Using paperless payment process [Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)] and other electronic financial settlement tools such as Claim Reconciliation Tool.
- Using clinical electronic tools such as Patient Care Summary.
- Submitting claims electronically in the HIPAA 5010 format or subsequent versions mandated by the federal government.
- Submitting medical records electronically.

Health Plan Transactions

HIPAA-AS compliant transactions available online in real-time and by electronic data interchange in batch include:

- ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response
- ASC X12N 276/277 Health Care Claim Status Request and Response
- ASC X12N 278 Health Care Services Review – Request for Review and Response
- ASC X12N 835 Health Care Payment/Advice
- ASC X12N 837 Professional Health Care Claim/Institutional Health Care Claim

You may submit electronic transactions directly through Availity or through a billing service, which will then use Availity to submit claims to us. However, you must be connected to Availity to conduct Eligibility and Benefits inquiries, Health Care Services Review and Inquiries (authorizations and referrals), submit claims and view remittances. These services are offered at no charge to providers.

Government Connections

Availity supports real-time Eligibility and Benefits, batch claims, and online Claim Correction for Medicare and Medicaid transactions in Florida. Florida Medicaid transactions are available at no cost. Medicare services are optional and are available at a nominal fee to providers.

Other Blue Plans

Availity supports certain other electronic transaction capabilities for other Blue Plans such as Eligibility and Benefits, Claim Status, and Health Care Services Review. The electronic inquiry transaction for existing referral authorizations for other Blue Plan members is not available at this time. Hours of operation for other Blue Plans will vary. Time zone differences also affect availability, although some Blue Plans may have extended hours of availability.

Florida Blue Hours of Availability for Electronic Transactions

Hours of operation for eligibility and benefits, claims submission, and Health Care Services Review and Inquiries are:

Monday through Saturday 12 a.m. – 11 p.m. Eastern Time
Sunday 12 a.m. – 5 p.m. Eastern Time

Hours of operation for claim status inquiries are:

Monday through Saturday 24 hours a day
Sunday 12 a.m. – 5 p.m. Eastern Time

Occasional system maintenance may affect hours of availability. If the system is unavailable, the Availity website will display an announcement.

Telephone Self-service tools

Twenty-four hours a day, seven days a week, Florida Blue offers an automated, self-service Interactive Voice Response (IVR) telephone system for Providers to inquire about member eligibility and benefits, and claims payment statuses. IVR self-service gives you the option to speak using your own natural language to navigate the telephone system.

Telephone Self-Service Tips

- When using natural language speech recognition, be sure to use your telephone handset or a headset for optimal recognition. Speakerphones are not recommended, as unexpected results can be received due to background noise.
- When entering the member's ID number be sure to enter only the numeric portion, and include any numeric extensions (e.g., -01 or -02).
- When supplying the provider number for claims status, be sure to use your Florida Blue provider number or NPI that was billed as the Payee. If any other provider data is given (do not use the performing provider number), the system may return "claim not found" in error.

Claims List –Self-Service Commands:

After entering your billing NPI provider number, the member's ID number and the date of service, the system will indicate how many claims were found for the data entered. It will respond with a list of each claim, providing the charged amount and claim number. You can navigate through the claims list with the following commands:

Note: Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts may change as additional claims are processed.

Claims Menu Options	Speak the key words below:
To repeat information:	"Repeat that."
To get details about the claim requested: Details include: Total charge, total paid, check number, check date, check payee, claim status and claim number.	"Hear line item details."
To search for another claim:	"Search another claim."
To start over with a new search criteria by returning to the main menu:	"Return to the main menu."
Multiple Claims Menu Options	**Speak the key words below:**
This is the claim you want to hear about	"That's the claim."
To hear the list of claims again:	"Hear the list again."
To hear a claim's line-level details:	"Details"
Start over with a new search criteria	"New search."
To return to the main menu:	"Main menu"

Eligibility & Benefits List – Benefit Information

Contract Information Disclosed:

Note: Benefits are subject to all contract limits and the member's status on the date of contact with Florida Blue.

After entering your billing NPI number and the member's ID number, the IVR will disclose:

- Contract status
  - Active?
    - Delinquency Status
    - Effective Date (The IVR will disclose future effective dates if applicable.)
    - Benefit Period
    - Pre-existing condition wavier status and waiting dates
    - Plan type (i.e., HMO, PPO, etc.)
    - Primary Care Physician, if applicable, with effective date
    - The Billing NPI's participating status with the member's plan type
    - Group number
    - Other carrier information, secondary and tertiary, if applicable
  - Inactive?
    - Termination Date

Again: Note that Benefits are subject to all contract limits and the member's status on the date of contact with Florida Blue.

For Eligibility and Benefit information for **out-of-state** members, please call the national Blue Cross Blue Shield Eligibility Line at (800)676-2583. Please have the member's 3 character alpha prefix ready.

Eligibility & Benefits List by Service Type –Self –Service Commands:

Note: Only a subset of service types are provided through the phone system. You can find benefits information for all service types on www.Availity.com.

Eligibility and Benefits Menu Options	Speak the key words below:

Get benefits for **Professional** medical services rendered in an office setting:	"Professional"
	    • "Sick Office Visit"
	       ○ "Consultation Only"
	       ○ "Dermatology"
	       ○ "Medical Pharmacy"
	       ○ "Professional Office Visit"
	       ○ "Sick Office Visit"
	    • "Well Office Visit"
	       ○ "Gynecological"
	       ○ "Medical Care"
	       ○ "Professional Physician"
	       ○ "Professional Office Visit"
	       ○ "Well Office Visit"
	 "Pediatric"
	 "Chiropractic"
	 "Maternity"
	 "Allergy"
	       ○ "Allergy"
	       ○ "Allergy Testing"

Get benefits for **Facility** services.	"Facility" "Hospital Outpatient" "Hospital Inpatient" "Emergency Services" "Rehabilitation" "Ambulatory Surgery Center" "Skilled Nursing Care"

Get benefits for **DME**, or Durable Medical Equipment.	"DME"
	    "Purchase"
	    "Rental"
	    "Both"

Get benefits for **Physical Therapy** services.	

Get benefit details based on "**Diagnostic**" Service Type	"Diagnostic"
	    "MRI"
	    "CT Scan"
	    "X-ray"
	    "Laboratory"

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Get benefit details based on "**Mental Health**" Service Type	"Mental Health""
	"Provider Outpatient"
	"Provider Inpatient"
	"Facility Outpatient"
	"Facility Inpatient"
	"Hear them all"

Note that after selecting the desired benefit type, the IVR will disclose the following information, and in the following order:

- In-Network Benefits or Out-of-Network Benefits
    - deductible amounts: individual, and family, if applicable
    - deductible remaining to be met as of the time of your call
    - whether or not applies to the desired service type
    - co-insurance information
    - whether or not an authorization is required
    - exclusions
    - co-payments when applicable
    - health plan limitations (e.g., life-time maximums)

Eligibility and Benefit Menu Options	Speak the key words below:
To repeat information:	"Repeat that."
To request an authorization for the service that just had benefits reviewed:	"Request an authorization for this service."
To query for benefit information for another service type:	"Look up information for another service type."
To start over with a new search criteria by returning to the Main Menu:	"Return to Main Menu"

Availity Issues:

For Availity issues, please call 1-800-AVAILITY; that's 1-800-282-4548.

Authorizations

We encourage physicians and providers to use Availity®1 to request Health Care Services Review Requests (authorizations or certifications) online. Access the Authorization/Referral Results Page in Availity. At the top of the screen, you'll see a button called Automated Fax Cover Sheet.

When the Availity Authorization/Referral Results page shows Pended for status reason Requires Medical Review, you will see an Automated Fax Cover Sheet button at the top of the page.

When you click on the automated fax cover sheet button, you'll receive a pre-populated fax cover sheet. This cover sheet was designed to be optically scanned so you can attach additional information for pended authorization requests electronically.

All you have to type in the new cover sheet is your phone number, and the fax number you're sending the information to before saving the data for a digital fax or printing it.

Tips for Faxing a Cover Sheet Digitally

• Important: Make sure the cover sheet is the first page. If you fax a digital copy, the fax cover sheet must be inserted as the first page before any other documents or the scanning system will not be able to read it. If another document is inserted as the first page, your request will default to the standard precertification fax number, and your review may take longer.

• Make sure the authorization or reference number on the cover sheet is correct. This is very important. If the number isn't right, a review of the authorization request could be delayed.

• Do not fill out the automated fax cover sheet by hand. The scanning system cannot recognize data that is written by hand.

Tips for Faxing a Paper Cover Sheet

• After saving the data, click on the "Print" button to get a copy of your pre-populated fax cover sheet.

• Important: Make sure the cover sheet is placed on top of any medical records or other information that you plan to fax to us. If another document is the first page, your fax will go through the standard precertification system, and your review may take longer.

• Make sure that the authorization or reference number on the cover sheet is correct. This is very important. If the number is not right, a review of the authorization request could be delayed.

• If you don't print the fax cover sheet right away when you receive a Requires Medical Review message, you can do an Authorization/Inquiry later in Availity to access the Automated Fax Cover Sheet button.

Accessing the New Fax Cover Sheet Through floridablue.com

You can also find the new fax cover sheet on the Florida Blue website at floridablue.com. Go to floridablue.com; select Providers at the top of the page, Tools & Resources, and then Medical & Pharmacy Policies and Guidelines. Select Services That Require Preservice Review under What's New on the left navigation bar, and then Preservice Medical Review Fax Cover Sheet.

Other Resources

• To find certificates of medical necessity online, go to floridablue.com, select Medical & Pharmacy Policies and Guidelines, and then Services That Require Preservice Review under What's New.
• For information about obtaining authorizations, please visit the Manual for Physicians and Providers on our website at floridablue.com.

If you do not have access to Availity or if the system is not available, use Blue Express.

When you select authorizations on our automated telephone system for physicians and hospitals you can inquire about or request authorizations and referrals for Florida Blue members.

It allows you to:

- Inquire about an authorization or a referral from or to you
- Request authorizations or referrals to participating providers for:
    - Inpatient hospital admissions
    - Office services

Note: Blue Express is only available for participating providers who have a Florida Blue provider number or registered their NPI with Florida Blue. Blue Express cannot be used for authorizations or referrals to non-participating providers.

Blue Express can be used for the following HMO and PPO products:

- HMO (BlueCare®, SimplyBlue and BlueMedicare℠ HMO)
- PPO (BlueChoice®, BlueMedicare℠ PPO, BlueMedicare℠ Regional PPO, BlueOptions℠, BlueSelect, Federal Employee Program (FEP), and State Employees' PPO Plan)

We encourage physicians and providers to use [Availity®1](#) to request Health Care Services Review Requests (authorizations or certifications) online. If you do not have access to Availity or if the system is not available, use Blue Express.

[1]Availity, LLC is a multi-payer joint venture company. For more information or to register, visit Availity website at Availity.com.

Information Needed to Create an Authorization:

Member	• Type of contract (Florida or FEP) • ID number • Date of birth • Gender
Provider	• Referring from provider number • Referring to provider number/facility • Attending/admitting provider number (if applicable)
Outpatient	• Surgical/radiation therapy procedure code(s) (if applicable)
Inpatient	• Type of admission (elective, urgent, emergency) • Source of admission (physician, ER, other) • Surgical procedure code(s) (if applicable) • Surgical date (if applicable)
Authorization	• Date of service – admission/service • Diagnosis code(s)

For authorization requests that cannot process through Blue Express, you will receive a message, "We are not able to process your request through the Blue Express system. For this request, please contact Florida Blue.

Note: Following an authorization request entry, you may say "New request" to enter another authorization.

You may interrupt the voice prompts at any time by saying or entering your response; you do not have to wait for all menu options. At any time during your call, you may say:

- "Repeat" – to repeat the previous message or menu
- "Help" – to receive detailed information about the current prompt
- "Main menu" – to return to the main menu
- "Goodbye" – to end the call

    All input will be validated by asking the caller to verify the information entered.

Frequently Used Telephone Numbers and Information:

Provider Contact Center Toll Free Number (800) 727-2227

- Provider Contact Center Hours of Operation: Monday-Friday 9 a.m. – 6 p.m. EST

Blue Express (800) 397-7337

- Blue Express Hours of Operation: Monday-Saturday 12 a.m. - 11 p.m. EST; Sunday 12 a.m. - 5 p.m. EST

For authorization requests that cannot process through Blue Express, you will receive a message, "We are not able to process your request through the Blue Express system. For this request, please contact our Utilization Management department."

www.Availity.com

Blue Express Alpha-entry Instructions:

When using the telephone keypad, alpha entry for provider number, diagnosis code, and procedure code may require you to press three keys as follows:

1. Press the asterisk (*) key;
2. Press the key on which the letter appears; and
3. Press the number 1, 2, 3, or 4 to indicate the position of the letter on that key.

For example:

- A is entered as * 21;
- V is entered as * 83;
- Z is entered as * 94

For :	Enter:	For :	Enter:	For:	Enter:	For :	Enter:
A	*21	H	*42	O	*63	V	*83
B	*22	I	*43	P	*71	W	*91
C	*23	J	*51	Q	*72	X	*92
D	*31	K	*52	R	*73	Y	*93
E	*32	L	*53	S	*74	Z	*94
F	*33	M	*61	T	*81		
G	*41	N	*62	U	*82		

Electronic Self-service tools

Electronic self-service tools for providers are available through the [Availity](#) and [Florida Blue](#) website. The tools and forms available on these sites can help providers reduce administrative costs, improve office workflows, and assist in the collection of claim payments. Checking Availity each time will ensure you receive the most recent member information.

Providers should always utilize self-service tools prior to contacting Florida Blue. We have the fast path priority service process, using an Availity transaction ID (fast path code), to encourage providers to use Availity before calling the Provider Contact Center for benefit information. This transaction ID will provide fast path priority service if you should need to call Florida Blue for assistance. Providers will not receive eligibility and benefits information from Florida Blue without a transaction ID. If calling the Provider Contact Center without an Availity transaction ID (fast path code), expect longer wait times for your telephonic inquiry.

Electronic Capability and Participation

Providers and/or their designees (billing services, clearing houses, etc.) are required to use clinical, financial and administrative electronic self-service capabilities including those accessed through Availity. These capabilities include but are not limited to:

- Submitting administrative inquiries electronically through Availity using Authorizations and Referrals Review and Inquiry, Eligibility and Benefits, CareCalc, Claim Reconciliation Tool and Claims Status.
- Using paperless payment process there are tools [Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)] and other electronic financial settlement tools such as Claim Reconciliation Tool.
- Using clinical electronic tools are valuable such as Patient Care Summary.
- Submitting claims electronically in the HIPAA 5010 format or subsequent versions mandated by the federal government.
- Submitting medical records electronically.

NOTE: A condition of a providers continued participation with us is full utilization of the electronic capabilities set forth above via secured electronic means. Providers ordering labs or other diagnostic tests for Florida Blue members agree to allow Florida Blue to share the results with the member are other treating physicians. If providers utilize electronic technologies that meet the criteria of CMS "meaningful use", they will make every effort to use the same technology with us and on behalf of our members. Providers sharing medical records with us agree to allow us to share the medical records with the members' other treating physicians via secured electronic means.

At our request, providers will direct their vendor(s) to work with us on their behalf to integrate this electronic technology into their system(s). Providers agree to integrate Clinical Exchange Capabilities (CIE) with us.

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Health Plan Transactions

HIPAA-AS compliant transactions available online in real-time and by electronic data interchange in batch include:

- ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response
- ASC X12N 276/277 Health Care Claim Status Request and Response
- ASC X12N 278 Health Care Services Review – Request for Review and Response
- ASC X12N 835 Health Care Payment/Advice
- ASC X12N 837 Professional Health Care Claim/Institutional Health Care Claim

You may submit electronic transactions directly through [Availity](#) or through a billing service, which will then use Availity to submit claims to Florida Blue. However, you must be connected to Availity to conduct Eligibility and Benefits inquiries, Health Care Services Review and Inquiries (authorizations and referrals), submit claims and view remittances. These services are offered at no charge to providers.

Government Connections

[Availity](#) supports real-time Eligibility and Benefits, batch claims, and online Claim Correction for Medicare and Medicaid transactions in Florida. Florida Medicaid transactions are available at no cost. Medicare services are optional and are available at a nominal fee to providers.

Other Blue Plans

[Availity](#) supports certain other electronic transaction capabilities for other Blue Plans such as Eligibility and Benefits, Claim Status, and Health Care Services Review; the electronic inquiry transaction for existing referral authorizations for other Blue Plan members is not available at this time. Hours of operation for other Blue Plans will vary. Time zone differences also affect availability, although some Blue Plans may have extended hours of availability.

Florida Blue Hours of Availability for Electronic Transactions

Hours of operation for eligibility and benefits, claims submission, and Health Care Services Review and Inquiries are:

Monday through Saturday 12 a.m. – 11 p.m. Eastern Time
Sunday 12 a.m. – 5 p.m. Eastern Time

Hours of operation for claim status inquiries are:
Monday through Saturday 24 hours a day
Sunday 12 a.m. – 5 p.m. Eastern Time

Occasional system maintenance may affect hours of availability. If the system is unavailable, the [Availity](#) website will display an announcement.

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Administrative Solutions

Providers should always conduct business electronically with Florida Blue. A wide range of self-service options are available, including the following provider administrative tools:

- Eligibility and Benefits
- Claim Status
- New Claim Status (NCS)
- Claims Reconciliation Tool (CRT)
- Clear Claim Connection
- Electronic Claim Submission
- Real-Time Claim Adjudication

Eligibility & Benefits Inquiry and Response

The [Availity](#) ® Health Information Network Eligibility and Benefits transaction provides documented real time benefits that can be printed and handed to patients. The chart below outlines the benefit categories a registered user can view for each Service Type dropdown selection. When a Service Type option is selected, the corresponding benefit groupings will be displayed by selecting "*view additional benefits*". In order to get deductible information you will need to select "*view additional benefits*" and go to Health Benefit Plan Coverage Service Type.

- Contract level deductible amounts, if applicable can be viewed by selecting a specific service type, then View Additional Benefits, then Health Benefit Plan Coverage. Medical Coverage Guidelines and Florida Blue Products and Plans which contains a provider manual for Blue can be accessed through a link on the bottom of the Eligibility and Benefits result screen.
- Additional information can be found in the Plan/Product section.
- Benefits are provided for Florida Blue, BlueCard and FEP members.
- The Eligibility and Benefits results screen provides access to CareCalc, CareCalc Facts, Patient Care Summary, FB Products & Plans, Care & Coding Reminders and Medical Coverage Guidelines.

Eligibility & Benefits Patient Care & ICD-10 Coding Reminders

We know that your patients count on you for the care they need to stay as healthy as possible. Here at Florida Blue, helping our members get and stay healthy is one of our main goals, too. So when it comes to making sure your patients receive their recommended care for chronic health conditions including annual and periodic preventive screenings, we look for new ways to help influence the timely completion of this care for our members.

You will see important patient care/coding reminders when visiting Availity to check on our members' eligibility for care and services. Care/coding reminders will be based on clinical and administration information previously sent to us.

Eligibility & Benefits Inquiry Screen

The Eligibility & Benefits Inquiry and Response transaction in Availity allows providers to electronically verify a member's contract benefit information in a matter of minutes. However, keying information incorrectly can cause delays in receiving the information you need.

Streamline the way you key and submit an Eligibility & Benefits (E&B) Inquiry by following a few simple guidelines and helpful hints.
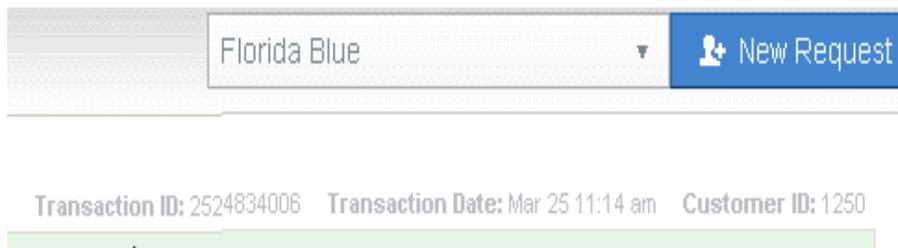
- Take time to be precise. Using shortcuts can cause keying errors, resulting in the need to re-keying or submit information multiple times.
- Be certain to key the most current member data correctly the first time as it appears exactly on the ID card. (Please note: middle initial is not required) Keying the member's data exactly as it appears on their ID card ensures an accurate response.
  - Please do not use social security numbers in the Patient ID field.
- Please allow sufficient time for newborns to be added to our enrollment system. This can take up to an average of 30-days. If a newborn's information is not returned after this time, call the card holder and request he/she contact their benefit administrator.
- Swiping the member's ID card through a magnetic card reader will automatically populate applicable patient information accurately the first time and eliminate key strokes. Card readers can be purchased at many business retailers, office supply stores and can be found online by searching for "magnetic card reader." The card readers must adhere to the following specifications:
  - Capable of reading tracks one, two, and three on a magnetic stripe.
  - Connects to your computer using a USB cable. Note that a separate power cord is not needed. The reader receives power from the computer through the USB cable.
  - It must be a keyboard emulation device.
- When referring the member to a specialist, provide a copy of the member's health insurance card to the specialty group (e.g. anesthesiologists and/or laboratories).
- If you continue to receive E&B errors, please contact the member to validate their information.

Fast Path Priority Service

After an Availity E&B inquiry transaction has been completed, note the transaction ID number at the top of the screen. This number is also known as the fast path code, which you will enter when prompted by the Provider Contact Center's IVR system. The use of this code is required to receive priority routing to a service representative.

Fast Path Priority Service process for E&B

1. Complete an E&B transaction
2. Select Review Member Details/Summary
3. The fast path code (transaction ID) will be located on the upper left corner of the summary page

Florida Blue ▾	👤+ New Request

Transaction ID: 2524834006　　**Transaction Date:** Mar 25 11:14 am　　**Customer ID:** 1250

Care Read

CareRead allows health care providers to swipe a patient's member ID card through a card reader and automatically populate Availity transaction pages with the information, eliminating the need to manually key it. Card readers can be purchased at many business retailers or can be found online by searching for "Magnetic Card Reader".

Claim Status

The Claim Status Inquiry screen allows you to view the status of submitted claims. To request a Claim Status, click Claims & Payments and then click Claim Status Inquiry. You do not have to submit claims through Availity for you to view their status.

A Claim Status Inquiry can be submitted immediately by clicking Submit or the Inquiry can be added to a batch for submission later by clicking Add to Batch. The response returned displays billing, subscriber, patient, and claim information.

New Claim Status Tool

The New Claim Status tool (NCS) is a multi-payer web-based tool built by Availity, which allows providers to view the summary and details of claims that have been previously submitted to Florida Blue. This tool will replace CRT, which will be retired. This tool provides information which is not available on the standard HIPAA compliant claim status capability.

To access New Claim Status: click Claims & Payments, Claim Status (New), and select Florida Blue as the payer. This will route you to the New Claim Status multi-claim display search tool.

Helpful Hints:

Select Florida Blue under any circumstance where Florida Blue is adjudicating the claim. This includes Blue Card claims where Florida Blue is the host plan.

- If another payer is selected, including "Other Blue Plan" this will route the user to that payers preferred claim status view. For other payers, this may not be New Claim Status.

If you do not have access, the PAA of your Availity org can grant access. To find your PAA, first, select the "Who controls my access?" hyperlink at the top of the Availity screen.

If you do not see your billing NPI in the search drop down, please click the help menu located next to the field and follow instructions to ensure registration was set up correctly.

Once inside, the new tool allows you to start your claim status search using just an NPI number and date range. If you are looking for specific information, you can refine your search by adding:

- Check/EFT number
- Claim status
- Patient ID number
- Patient account number
- Claim Number

The results in NCS can be displayed in a list or detail view. The screen defaults in a list view of all claims. Click a claim summary card or use the button in the upper right corner to change the view to "Detail View", to see the claim details.

Once clicked, the details are available in the right pane in the viewer. Review and scroll to see information about the claim detail lines, such as itemized distribution, HIPAA codes, Florida Blue remarks, revenue codes and other pertinent claim and claim line details.
　　　Note: You can hover over the (i) icons to see expanded descriptions of indicators and remarks.

Color coding visually shows claim status. Red designates non-paid, yellow represents pended, and green represents paid. Additionally, blue is a custom Florida Blue status which represents returned claims. These claims were not accepted by Florida Blue and must be resubmitted.

Denied for eligibility? To check the member's eligibility:

- In the "detail view" for a claim, click "Get Eligibility and Benefits", to see a basic eligibility response about the member on the claim, as of the date of service of the claim.
- If more information is needed, link out to a full response by clicking "View in Eligibility and Benefits."
  - o Helpful Hint: There is no need to enter the information for the member. The member's information has been saved for you in the left hand pane. Click the member's name to run the full Eligibility and Benefit response.

Need more information about the remittance? To check remittance:

- At the top right of the screen, select the "Go To" button and select "Remittance Viewer."
- Once clicked, the screen will exit the claim status tool and navigate to the "Remittance Viewer," so further research can be done.
  - o Helpful Hint: If you are not done in the claim status tool, you can open "Remittance Viewer" in a new tab and toggle back and forth. To do this, click "Go To", then right click the "Remittance Viewer" and select "Open in New Tab."

Fast Path Priority Service process for NCS

After an NCS detail inquiry transaction has been completed, by click on a summary card, note the transaction ID appears on the bottom of the details screen. This number is also known as the fast path code, which you will enter when prompted by the Provider Contact Center's IVR system. The use of this code is required to receive priority routing to a service representative.

- Complete an electronic NCS transaction, then scroll to the bottom of a claim detail card to retrieve the fast path code (transaction ID).
- If you need additional claim status information for that specific member, call the Provider Contact Center.
- You will be prompted to enter the fast path code (transaction ID) before you hear the main menu options.
- Your call will be automatically routed to the appropriate area as a priority call.

Claim Reconciliation Tool

The Claims Reconciliation Tool (CRT) is a web-based tool built by us to enable providers to view a summary of claims that have previously been paid, rejected or pended. The CRT is offered exclusively by us and accessed through Availity, but will be retired and replaced with New Claim Status. It provides additional information that is not available on the standard HIPAA compliant Availity claims status capability, allows providers to view multiple claims on multiple members, and provides our proprietary reason codes and descriptions.

Providers who have registered with Availity may access the CRT via a link; your Primary Access Administrator (PAA) must grant you access.

All PAAs should have access to the tool. Here are a few tips if Florida Blue is not viewed on the Availity screen:

- First, select the "Who controls my access?" hyperlink at the top of the Availity screen. If you are listed as the PAA, make sure that you are using the correct user ID if you have multiple logon IDs.
- If you are not listed as the PAA, the PAA must provide Florida Blue access to users. If the PAA is no longer employed at the office or needs to be changed, please fill out a PAA Change Request form that is available on the Availity website.
- If you are the PAA and do not have multiple user IDs, your account might have been inactive when Florida Blue's CRT was rolled out. Please contact Availity and request access to Florida Blue's CRT.

To access the CRT link, please follow these steps:

- Login to Availity
- Select the Claims Management option found on the left side of the screen
- Select the Claim Reconciliation link

You can search back 24 months from the current date. When requesting a date span of claims history, providers are limited to a 31-day span within 24 months of the current date.

The claim status types available include:

- Paid
- Finalized/Rejected/Non-Paid
- Pending
- All claims

You may choose to have results sorted by one of the following fields:

- Contract Number
- Patient Account Number
- Patient Last Name
  Note: If you do not request the claim results be sorted by one of the three above choices, then your results will be sorted by the Date of Service.

If you select the "Next" button to view CRT and nothing happens, there are three ways to resolve this issue:

- Disable pop-up blockers – Some offices may have multiple pop-up blockers under different navigation bars (e.g., Google, Yahoo!). These can be turned off and will provide access to the CRT. When you finished with the tool, you can turn on pop-up blockers.
- Allow Availity as a trusted site – To avoid turning on and off pop-up blockers, you can open the Internet Options on a browser window and can add www.availity.com as a trusted site.

- Manually bypass pop-up blockers – If the above options do not work or there seems to be a hidden pop-up blocker that cannot be found, you can hold down the "Ctrl" button and then select the "Next" button. This will bypass the pop-up blocker and the user should see the CRT disclaimer window.

Fast Path Priority Service process for CRT

After a CRT inquiry transaction has been completed, note the transaction ID number at the top of the screen. This number is also known as the fast path code, which you will enter when prompted by the Provider Contact Center's IVR system. The use of this code is required to receive priority routing to a service representative.

- Complete an electronic CRT transaction, then click the "Get Transaction ID" button on the CRT Detail Screen to retrieve the fast path code (transaction ID).
- If you need additional claim status information for that specific member, call the Provider Contact Center.
- You will be prompted to enter the fast path code (transaction ID) before you hear the main menu options.
- Your call will be automatically routed to the appropriate area as a priority call.

Clear Claim Connection

Simulate likely procedure code editing rules for Florida Blue claims prior to submission or after receiving the remittance advice by using Clear Claim Connection; available through Availity.

This tool is intended for use as a simulation for general information and is not binding on us. Medical Policies (Medical Coverage Guidelines), member benefits, terms, limitations and exclusions will prevail if there is a conflict with a payment edit.

Claims are adjudicated using claim processing rules for procedure code editing in effect at the time the claim is submitted. Procedure code edits are typically updated twice per year. Clear Claim Connection only returns current claim editing logic. Therefore, if your simulation results do not match how your claim processed, it is possible a version update may be the reason.

Claim editing rules are consistent for most Florida Blue and Florida Blue HMO claims. Medicare Supplement and Medicare Advantage claims however are not necessarily subject to the procedure code editing rules displayed by Clear Claim Connection.

How to Use Clear Claim Connection

From the Availity home page, under the Claims Management Menu tab, click on Research Procedure Code Edits. Next, you must accept the Terms and Conditions of Use. On the next page displayed select the Clear Claim Connection Link which will take you to the Claim Entry Screen. On the Claim Entry screen, provide the data listed below and click on the Review Claim Audit Results button. The information returned is confidential and solely for the use of authorized provider practices.

- Patient's gender
- Patient's date of birth
- Procedure code
- Up to four diagnosis codes
- Place of service (system will default to the Office (11) Place of Service if nothing is entered
- Modifiers, if applicable (optional data field)
- Date of service (needed to determine active and non-active procedure codes)

This capability also provides source information and clinical rationale for editing rules, but only on procedure lines with a "Disallow" or "Review" response in the "Recommended" data field. To view this additional information, click on the line to highlight it, and then click the Review Clinical Edit Clarification button. You can also double click the line to review the related clinical edit clarification.

Note: Use of Clear Claim Connection requires Internet Explorer 5.5 SP1 or higher. For those using a pop-up block, this may need to be disabled to view the site. This tool cannot be used for outpatient institutional claims analysis.

Electronic Claim Submission

Electronic Claim Submission allows providers to safely submit and track HIPAA-compliant electronic claims to Florida Blue 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 limited number of payer specific edits are also performed before routing transactions.

If a claim transaction fails either the HIPAA-AS or Florida Blue edits, Availity will not forward the claim for payment.

Availity will return an error message to the sender (sender is defined as the entity that submitted the claims to Availity; this may be a provider, billing service, or another clearinghouse) to correct and resubmit the claims electronically. If you use a billing service or another clearinghouse to submit your transactions to Availity, it is the billing service/clearinghouse's responsibility to return the Availity file acknowledgements and EBRs to you.

Note: A clearinghouse, billing service or information management system may have electronic claim validation processes in place. Senders should contact their vendor with questions about these differences. Availity offers online real-time and batch EDI claim submission options. The responses returned to the sender are different.

- Claims can be entered on the Availity web screen and submitted to us using Availity online real-time claim submission transaction. A real-time adjudication response or an acknowledgement indicating that the claim has been forwarded for further processing is returned to the sender. This response is received within minutes.
- Claims can be created in a billing system and submitted to us using Availity EDI batch submission functionality. A file acknowledgement that explains the file's acceptance or rejection by Availity is usually returned within minutes. Availity will return an EBR, usually within minutes, that lists total number of claims submitted, total claims accepted by Florida Blue and detailed information on claims that failed the HIPAA or Florida Blue edits. Providers may also choose to receive detailed information on all accepted claims as well. Claims listed as failed should be corrected and resubmitted electronically in a new EDI batch file with a unique batch transaction ID.

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 website for [electronic transmission support](#) information.

Electronic Submission of Corrected Claims

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.

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

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 /Update of a 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.

A replacement claim should contain **all** procedures submitted for processing because it will **replace** the previous claim. If a replacement claim is received with only new additional charges, only those charges will be processed. Any services billed on the original claim but not on the replacement claim will generate an overpayment recovery. The original claim number must be included in the following places on the transaction;

Loop/segment (837P/I Guide 005010X222 2300 Loop)

- CLM01 1028 Claim Submitter's Identifier M 1 AN 1/38
- CLM05 - 3 1325 Claim Frequency Type Code O ID 1/1
- CLM05 - 3 1325 Claim Frequency Type Code O ID 1/1

EBR message - Claims submitted with a frequency 7 must have a valid original claim number in loop 2300 segment CLM05.

8 – Void/Cancel of Prior Claim

If you have submitted a claim in error, resubmit the entire claim. If the claim was paid, resubmit the claim to Florida Blue using the Claim Overpayment Refund Form.

Professional Real-Time Claim Adjudication

With RTCA, you can seamlessly convert from a CareCalc member responsibility determination straight to the submission of a real-time claim, saving you the time and inconvenience of completing lengthy paperwork. Neither you nor the member will pay additional costs or fees when you use these helpful tools. RTCA delivers a whole new consumer experience by combining patient eligibility, member financial responsibility, real-time claim adjudication and real-time response. RTCA enhances CareCalc by allowing real-time claim submission and completes the member/provider transaction. This capability can simplify reconciliation and streamline a provider practice's administrative duties. The RTCA option is only available after completing a successful CareCalc inquiry. CareCalc and RTCA are currently available to select BlueChoice, BlueOptions, Florida Blue HMO, BlueMedicare HMO, BlueMedicare PPO, GoBlue plans and Miami-Dade Blue plans. Also some other blue's plans are eligible.

Information to consider when submitting a RTCA transaction:

- RTCA can be used for professional services rendered in the office (11), home (12), outpatient (22), ASC (24), urgent care (20), emergency room (23), independent clinic (49), and independent lab (81).
- It is only available after completing a successful CareCalc inquiry. If the "Submit" button is not active, the transaction is not eligible for RTCA.
- RTCA is available for PA provider groups and has a section that allows you to enter rendering provider information when it differs from the billing provider.
- Claims cannot be changed through RTCA. You can submit a corrected claim electronically in Availity.

RTCA Messages

The following actions should be taken when RTCA summary indicates the below messages:

- "Your claim has been successfully processed. Please review the information below. If you have questions about the responses, please contact your payer."
  - RTCA users will receive this message when Florida Blue has successfully received and processed their claim. You can either verify claim status on Availity or CRT or can await their paper or electronic remittance advice.
- "Your claim has been submitted successfully. However, this claim requires additional review. You will be notified if additional information is required" or "Florida Blue has processed your claim".
  - RTCA users will receive this message to acknowledge that Florida Blue has received their claim submission. Whenever possible, Florida Blue will return a claim number enabling providers to check the status on Availity or CRT. In some instances these claims may require further review. You will be contacted if additional information is needed.

 Note: This tool cannot be used for outpatient institutional claims analysis.

Clinical Solutions

Providers should always conduct business electronically with Florida Blue. A wide range of self-service options are available, including the following clinical tools:

Authorization and Referrals Inquiry, Update and Voids

To request approval (authorization, certification or notification) for services through Availity, enter all requested data on the applicable referral or authorization screen and submit.

Inquiries

To validate, inquire, update or void (cancel) an existing admission certification, notification or authorization request using Availity (need hyperlink), select Authorization/Referral Inquiry. The requester must be authorized to view the response.

To inquire about existing service requests:

- Select Auth/Referral Inquiry under the Auths and Referrals menu
- Complete the required fields to search
- Select the appropriate request from the results list if applicable
- Click Submit

Referral Tool Enhancement for PCPs Choosing Specialists for Members

Florida Blue and Availity[1] introduced enhancements to the Referral self-service tool for primary care physicians to refer their patients, our members, to specialists participating in our health plans.

Through the Referral tool's new feature, "enhanced referral", primary care providers will be able to obtain participating specialist information in real time. They will also have the ability to easily identify specialists within close proximity to the patient's home zip code and who best matches the specialty/taxonomy code provided.

Please note that the "enhanced referral" functionality will be utilized for all Florida Blue products that require specialist referrals. Those products currently include myBlue, BlueMedicare HMO, and BlueMedicare HMO Plus.

How to demo the Referral tool's latest enhancement:

Visit Availity.com to access the demo and see how this new feature will aid in the specialist referral process. Click **Help & Training** | **Get Trained**, and search by keyword Referral.

After viewing the demo, you'll want to get access to the Referral tool's new feature so ask your organization's Availity administrator to give you the medical access role. To get the tool, click on your notification in the Availity website Notification Center or go to the Florida Blue Payer Spaces and click on the Enhanced Referral title under Applications.

Updates

To update existing requests:

- Select Auth/Referral Inquiry under the Auths and Referrals menu
- Complete the required fields to search
- Select the appropriate request from the results list
- Click the Update button and complete the changes
- Click Submit

Changes can be made only when:

- Current status is Approved or Held if applicable;
- Admission or Service From Date is in the future; and
- No claims have been received for the authorization.

The select fields that can be updated are:

- Service dates
- Procedure date(s) (Procedure codes can be added, but cannot be deleted or modified)
- Referred to provider
- Referred to facility
- Additional and referred to provider

Voids eCensus Tool

To void (cancel) existing requests:

- Select Auth/Referral Inquiry under Auths and Referrals menu
- Complete the required fields to search
- Select the appropriate request from the results list
- Click the Void button to cancel the request if applicable

Note: The Update and Void buttons are only visible to providers who have access to change a specific request and when the request status is approved or held.

The eCensus Tool allows primary care physicians to receive admission, discharge, and transfer hospital event updates for their Florida Blue BlueMedicare HMO and myBlue patients.

It will be much easier for you to keep track of your patients' hospital progress and provide follow-up care. Each patient's information is featured in a "patient card" which is color coded so you can quickly understand their status (e.g., inpatient, pre-admit, recurring patient, outpatient, emergency). There is a filter option to help you narrow your results. This option will allow you to search by patient class (type of event), and facilities over the previous 90 days. Using filters and search options will help you save valuable time. Patient records will stay in your organization's eCensus list for 18 months.

How to get started with eCensus?

Visit Availity.com to view a 3.5-minute eCensus demo. Click Help & Training | Get Trained, and search by keyword eCensus.

To get the tool, click a notification in the Notification Center located on the Availity website or go to Payer Spaces for Florida Blue and click the eCensus tile under Applications.

Electronic Appeal

Submit appeals for previously processed claims electronically with electronic appeals.

To access the electronic appeals tool log on to Availity; select My Payer Portals, click on the Florida Blue PASSPORTTM link, select electronic appeals and then submit your electronic claim appeal with supporting documentation.

Passport is expanding to include automated appeal forms. The automated appeal forms will enable providers to submit an appeal and receive a real-time decision upon answering a series of questions.

The appeal is submitted through the Passport self-service platform and then routed to the Florida Blue care management platform baring the appeal form is available to the service being appealed. You will then be asked a series of questions and will be provided a real-time decision.

Deployment and utilization of the automated appeal forms will contribute to the mission of increasing the affordability of health care by reducing costs for both providers and the company.

The electronic appeal process is currently not available for the Federal Employee Program (FEP) or BlueCard® claims. Please use the current paper/written appeals process for these claims. If you have questions about accessing the electronic appeals tool please contact Availity. Electronic Appeals

Electronic Care Reminders

Care Reminders are clinical messages based on claims data that can be found within a Patient Care Summary and are intended to assist with identifying opportunities to improve the health of patients. The current electronic Care Reminders are based on Healthcare Effectiveness Data and Information Set (HEDIS) and the Centers for Medicare & Medicaid Services (CMS) Star measures.

For the complete list of the current Care Reminders shown in the Availity CareProfile® Clinical Messaging section, click here.

Clinical Quality Validation Forms

The Clinical Quality Validation (CQV) form is an easy-to-navigate web-based form that provides physicians with pre-populated care gaps identified from claims data relating to care and/or quality measures. The validation documents the assessment and care provided by the provider and attests that the information provided is true, accurate and complete.

To navigate to the CQV form login to Availity, go to Payer Spaces, Florida Blue, and select the tile for Clinical Quality Validation Form. If you do not have access, the PAA of your Availity org can grant access. To find your PAA, first, select the "Who controls my access?" hyperlink at the top of the Availity screen.

Once in the application, to access the demo, click the demo link in the upper right hand corner. To review Florida Blue specific instructions and FAQ's, select the FAQ link, under the demo.

Patient Care Summary

Access a consolidated view of a patient's claims information from multiple payers for two years of history. This clinically relevant information complements the physician's own medical records and can be viewed by the physician at the point of care for better-informed decision-making.

The Availity Patient Care Summary offers authorized physicians and health care providers real-time access to a consolidated view of a patient's health care service claims information from multiple payers for two years of history. This clinically relevant information complements the physician's own medical records and can be viewed by the physician at the point of care for better-informed decision-making. This tool is available at no charge to providers.

Availity Patient Care Summary information includes (to the extent available and permitted to be disclosed):

- Diagnosis details and associated procedures
- Physician office visits and hospitalization history
- Prescriptions history
- Lab and radiology test history
- Lab results
- Immunization history

Availity Patient Care Summary enhances physicians' decision-making at the point of care. It also:

- Supports coordination of care by allowing a treating physician to view certain services rendered by other providers.
- Complements the physician's own medical record by filling in gaps in the patient's medical history.
- Facilitates dialog with the patient.
- Helps reduce duplicate medical procedures, unnecessary services and health care costs.
- Alerts the physician to indicators of under-use, overuse or misuse of health care services.
- Is accessible from any location by authorized users even in times of catastrophic events so that appropriate treatment or service can be delivered to patients.

Financial Solutions

Providers should always conduct business electronically. A wide range of self-service options are available, including the following provider financial tools:

CareCalc

Determine an estimate of a member's financial responsibility in real-time by calculating the cost for them. Currently available for Florida Blue HMO, BlueMedicare HMO and PPO, BlueOptions, GoBlue, Miami-Dade Blue, select BlueChoice plans and some out-of-state (BlueCard) Plans.

General Overview

CareCalc is an innovative tool that enables providers to quickly and easily determine an estimate of a member's financial responsibility in real-time by calculating the cost for them. It is designed to fit into a provider's workflow so they can determine the patient's out-of-pocket responsibility whenever they need it prior to service, at the point of service or when the member checks out. The CareCalc response reproduces how a claim would process, including claim edits. The actual member responsibility will be determined when the provider submits the claim to us. There are no costs or fees to use this tool.

CareCalc is accessed through the Availity Eligibility & Benefits Inquiry. Providers enter the member diagnosis and treatment (procedure) codes into the CareCalc Member Responsibility Calculation screen. CareCalc responses are based on member benefits, provider contractual allowances, deductibles and benefit maximum accumulators available at the time of inquiry.

Although this tool is designed to ultimately serve all Florida Blue members, it is most valuable to those with high-deductible and/or coinsurance plans. CareCalc is available for some BlueChoice, BlueOptions, Florida Blue HMO, BlueMedicare HMO, BlueMedicare PPO, GoBlue, Miami-Dade Blue, and some out-of-state (BlueCard) plans. CareCalc is not available to some professional provider types (e.g. specialties related to anesthesiology, dental, pharmacy). CareCalc is only available for acute care hospital and ASCs for outpatient services only. Also, CareCalc is not available for FEP, and Medicare Supplement plans. The "button" that activates CareCalc will only appear when the member and provider are eligible for which CareCalc will operate.

Note: Providers who have one NPI mapped to multiple Florida Blue provider numbers may be adversely affected. The following providers will no longer have access to CareCalc and therefore will no longer see the CareCalc button:

- Professional providers with one NPI number mapped to multiple Florida Blue Id provider numbers with multiple fee schedules.
- Organizations that have physician groups and facilities/ambulatory surgical centers with one NPI mapped to multiple Florida Blue provider numbers with one fee schedule or multiple fee schedules.
- Organizations that have multiple facilities/ambulatory surgical centers with one NPI mapped multiple Florida Blue provider numbers with multiple fee schedules.

Other Blue Plans

CareCalc is available for some other Blue Plans including: BlueCross BlueShield of Alabama, BlueCross BlueShield Arkansas, Health Care Services Corporation (HCSC) for Texas, New Mexico, Oklahoma and Illinois, Highmark, BlueCross BlueShield of Kansas, BlueCross BlueShield of Mississippi, BlueCross BlueShield of South Carolina and BlueCross BlueShield of Tennessee.

When submitting an Eligibility & Benefits transaction for out-of-state members:

- Select Other Blue Plan in the Payer drop down menu
- Complete additional fields on the CareCalc inquiry as required (e.g., patient gender and patient responsibility may not be automatically populated and require selecting an appropriate response in the drop down menu)

CareCalc for BlueCard is available Monday through Saturday, 9 a.m. to 9 p.m. Eastern Standard Time.

CareCalc Messages

The following actions should be taken when CareCalc responds with the below messages:

- "Unable to determine patient liability, additional information is required. You may submit this transaction as a claim, further review maybe required." For a Florida Blue or out of state member:
    - Review and confirm the information submitted in the CareCalc inquiry (e.g., Have you entered an unlisted procedure code?). Make corrections as necessary. If you are still unable to determine patient liability, it is possible that manual review of the claim is necessary to determine appropriate coverage and pricing. If all information appears correct, contact the Provider Contact Center.
- "Unable to determine patient liability; additional information is required" for an out-of-state member
    - CareCalc may return this error message on the CareCalc inquiry screen when a response from the member's Home Plan is not received timely or the transaction has timed out. Please reviews the information submitted and resubmits at a later time.
- "Deny PA Group Claims"
    - Message applies to professional only
    - The provider rendering services is part of a group that will be paid for the services rendered. This will require you to provide the appropriate information for both the rendering provider and the group. For the rendering provider, return to the Eligibility and Benefits inquiry screen and populate the rendering NPI number for the provider who is rendering services in the NPI field.
    - For the group, on the CareCalc inquiry screen Provider select the Group Tax ID option in the Pay-To Provider Information section and enter your group's tax ID number in the Tax ID field.
- "COB information is not current"
    - It is the member's responsibility to provide other insurance information to Florida Blue annually. A form is mailed to members to complete or they can update their other insurance information online. As with any other calculation, CareCalc will determine an estimated member responsibility for those members who have not updated their other insurance information, but there is a higher likelihood that this amount may be different than the amount determined after the claim processes.
    - The Coordination of Benefits Questionnaire form is available on our website. You can print this form for your patients to complete and mail to Florida Blue.

Medical Services Requiring Authorization or Pre-Service Review

CareCalc will not relieve you of any obligation to obtain an authorization or pre-service review. Failure to follow utilization management requirements may impact your ability to bill and be paid for such services. Refer to the Utilization Management section for more information on obtaining authorizations.

Professional CareCalc Specifics

CareCalc can be used for medications injected at the office and billed by the physician that have a designated HCPCS or CPT code and cannot process unclassified codes that require the addition of an NDC code as the drug identifier.

Electronic Funds Transfer

Providers can receive claim payments directly deposited into their bank account. Our electronic funds transfer (EFT) enables physicians and providers to receive claim payments safely and securely by direct deposit to a designated bank account at the financial institution of their choice. The benefits of using EFT include:

- Quicker access to your claim payment funds
- Elimination of lost or stolen checks
- Increased administrative efficiencies and greater convenience
- Increased security of information
- Eligibility to receive electronic remittance advices (ERAs) which expedite patient account reconciliation

Providers with multiple office locations can now have funds automatically routed and deposited into multiple bank accounts. EFT transactions are faster than transferring funds by check and available for all of our products.

To register for the EFT service go online to www.availity.com or complete the Electronic Funds Transfer form for each payment location and attach a voided check or bank letter. Online registrations require scanned PDF documents. Paper based registrations require original documents.

If deposits for all payment locations are going to the same bank account you will only need to complete one registration (indicate NO on the online drop down box or ALL on the payment address line on the paper form).

If you are requesting direct deposit into multiple bank accounts, you will need to complete an online registration or paper form *for each office location and associated bank account*. If using the paper-based form please mail it to:

Florida Blue
Corporate Payables - DCC1-5
4800 Deerwood Campus Parkway, Jacksonville, FL 32246-8273

EFT registration takes approximately 24 hours from the date of receipt.

Once registered for EFT:

Payments are processed on a weekly schedule based on the zip code of the payment address. Funds are available approximately two days after the payment cycle. For example, the Monday payment cycle funds will be in the designated bank account on Wednesday.

We will only debit your account if we sent a duplicate file to the bank. Any payment reductions due to adjustments, netting, etc. are part of the claims adjudication process, which is completed before funds are transferred to your account.

You may receive checks for a small number of groups that have not migrated to our common claims processing system.

Manage your accounts using the 835 ERA. To receive 835 ERAs, providers must complete the 835 Health Care Electronic Remittance Advice (ERA) Registrations.

We administer bank accounts for different lines of business (e.g., Florida Blue, Federal Employee Program, Florida Blue (Health Options, Inc.), State Employees' PPO Plan and, ASO groups). You may receive multiple EFTs if you have multiple payment addresses and see members for these lines of business.

CAQH CORE Operating Rules requires the Electronic Funds Transfer (EFT) and the ERA to be transmitted within three business days of each other. Contact your Banking Institution in order to resolve a late/missing EFT payment. If your Banking Institution cannot resolve the late/missing payment, contact Florida Blue, Provider Contact Center, at 1-800-727-2227.

Electronic Remittance Advice

The Remittance Advice contains an explanation of claims payments, claims denials and other financial information necessary to reconcile patient accounts.

The 835 Electronic Remittance Advice (ERA) is the industry standard electronic version of a remittance advice and is intended to update the provider's accounts receivables systems automatically. In many instances, the 835 replaces the paper remittance advice altogether, alleviates manual handling associated with paper documentation, enhances workflow and reduces administrative burdens.

Providers can receive ERAs delivered to their Availity Receive Files mailbox or other mailbox as desired. Some billing systems can import the information to automate posting of accounts receivables. Providers interested in receiving ERAs should follow the instructions on the 835 Health Care Electronic Remittance Advice (ERA) enrollment document.

Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) are reported on the 835 ERA instead of payer's proprietary adjustment reason and denial codes. These standard reason and remark codes advise providers why payment may be different than the submitted charge. CARCs and RARCs are mandated by HIPAA-AS and the code definitions cannot be changed by Florida

Blue or any payer. Some CARC definitions can be more generic than Florida Blue proprietary codes while RARC definitions provide more specific information related to adjudication of the claim. Both CARC and RARC codes are used industry wide to avoid payer specific language. There are certain generic CARCs reported on the 835 ERA that require at least one accompanying RARC to be returned as well which will provide clear information regarding when claim payments are denied or reduced. To obtain the most recent and complete list of CARCs and RARCs, visit the Washington Publishing Company website.

CAQH CORE Operating Rules requires the Electronic Funds Transfer (EFT) and the ERA to be transmitted within three business days of each other. Contact Availity at 1-800-Availity (1-800-282-4548) in order to resolve a late or missing ERA transaction.

Remittance Viewer

The Availity Remittance Viewer enables users to view, search, reconcile and print Electronic Remittance Advice (ERA) or 835 files. Florida Blue proprietary information is included with the HIPAA 835 data. This solution, which stores up to seven years of remit information, replaces the paper remittance and is available the same day the financial cycle is completed at Florida Blue. This tool makes it easier to search and locate information by offering search options such as: Search by, Patient, Check/EFT number, or Claim number. Providers can also generate a PDF document and print or save it to their computer system.

Providers must be registered with Availity to utilize the web-based Remittance Viewer solution. To complete the free registration, visit www.availity.com, or call 1-800-282-4548. Availity also offers Remittance Viewer training at no cost. To view their training schedule, visit 'Training Resources' on the Availity website.

Member Solutions

Florida Blue offers various tools and resources to assist our members as they navigate through the health care delivery system. Learn more about these member tools, such as Care Comparison and the Member website so to encourage your patients, our members, to take advantage of the many self-service options available.

Member Website where members can login to:

- Check the status of a claim
- View your current benefits
- Find a specialist or a new doctor
- Compare drug costs
- Research health topics
- Update your personal information
- Make a payment

Member Tools

Care Comparison

Care Comparison is a Florida Blue transparency tool to assist our members as they navigate through the health care delivery system. Care Comparison is designed to allow members to evaluate the total cost of specific medical procedures and common office visits. The tool works by displaying facility specific cost information for common procedures (bundles) and quality information when available. A procedure bundle is the combination of one or more DRG and/or CPT codes for variations of the same core procedure.

Care Comparison is available to Florida Blue PPO and BlueOptions (NetworkBlue) members on our website via the Member website, a secure, members-only web portal. Members can also access Care Comparison by calling our Care Coordination team. Care Comparison is not available to the general public.

Care Comparison includes several features designed to protect the provider's fee schedule including, claims data, typical cost ranges, claims aggregation and the aggregation of multiple procedure codes (bundles). Provider-specific fee schedule information is not displayed in Care Comparison.

Data

Care Comparison is updated using 12 months of claims data. For each of the elective services, a minimum claims volume is required. Admissions or visits with combined service costs beyond two standard deviations from the average are not included in the display for the service. Hospital quality information is based on publicly reported data from the Agency for Health Care Administration (ACHA), and Center for Medicare & Medicaid Services (CMS), The Leapfrog Group and WebMD. WebMD complication rate data is risk adjusted, however, the cost bundles are not risk adjusted. Cost bundles reflect actual allowed dollars for the claim because the cost information is based on the average allowed amount. Patient Safety information is reported from The Leapfrog Group. For more information, visit www.leapfroggroup.org.

Methodology

Claims for procedures are combined (bundled) and an average allowed amount is created from facility, professional and ancillary services. A cost range is then determined for each procedure. Procedures included in Care Comparison come from inpatient, outpatient facility claims (and related physician claims), ASCs or free-standing radiology center settings.

Bundles

Bundles include the average professional cost, average facility cost and the average total allowed for one clinical event (e.g. inpatient admission or outpatient visit). Based on the percentage average, low and high cost ranges are calculated for each service. Standard ranges are in approximately 20 percent increments, with the low and high range being approximately 10 percent from the midpoint of the average for a given service or procedure.

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Services contained in a bundle include inpatient, outpatient and ASC. All facility and professional claims tied to a specific admission or procedure are bundled into a cost range, less the exclusions noted below. This information will be updated monthly.

Care Comparison Exclusions:

Radiology: imaging claims that include the professional modifier and do not have other claims.

Inpatient, outpatient and ASC: exclusions include cases coming through the ER and cases two standard deviations away from the mean. Cases with professional fees less than $500 for inpatient and $100 for outpatient are also excluded although these minimum dollar amounts can be less depending on the market. Outpatient cases will be excluded when non-facility service is higher than the facility service; the exception is anesthesia, which may cost more than the primary procedure. BlueCard claims will also be excluded.

Procedures (bundles) included in Care Comparison

Procedure Name	Category
Arm - MRI Upper Limb	Diagnostic Radiology
Back - MRI Spine	Diagnostic Radiology
Back Surgery - Laminectomy	Inpatient
Back Surgery - Laminectomy	Outpatient
Back Surgery - Spinal Fusion (Lower Back)	Inpatient
Back Surgery - Spinal Fusion (Upper Back)	Inpatient
Bariatric Surgery - Lap Band	Outpatient
Bariatric Surgery - Laparoscopic Gastric Bypass	Inpatient
Bladder Repair for Incontinence (Sling)	Outpatient
Breast - Biopsy using a special probe	Outpatient
Breast - Needle Biopsy (with Imaging)	Outpatient
Breast Lumpectomy	Outpatient
Bronchoscopy	Diagnostic/Outpatient
Bunionectomy	Outpatient
Cardiac Angioplasty - w/ Drug Eluting Stent	Inpatient
Cardiac Defibrillator Implant w/o Cardiac Catheterization	Inpatient

Procedure Name	Category
Childbirth - Normal Cesarean Section Delivery	Inpatient
Childbirth - Normal Vaginal Delivery	Inpatient
Colon - Colonoscopy with biopsy	Diagnostic/Outpatient
Colon - Screening Colonoscopy	Diagnostic/Outpatient
Coronary Bypass (CABG) w/o Cardiac Catheterization	Inpatient
Dilation & Curettage - D&C	Outpatient
Ear - Insertion of ventilating tube	Outpatient
Eye Surgery - Cataract Removal	Outpatient
Gall Bladder - Removal (by Laparoscope)	Outpatient
Groin - Hernia Repair 5 Years and Older	Outpatient
Hammertoe Correction	Outpatient
Hand Surgery - Carpal Tunnel	Outpatient
Head - CT Scan Head	Diagnostic Radiology
Head - MRI Brain	Diagnostic Radiology
Heart - Left Catheterization	Outpatient
Hip Replacement - Joint Replacement Surgery	Inpatient
Hysterectomy	Inpatient
Knee - Cartilage Repair (using Arthroscopy)	Outpatient
Knee - Ligament Repair (Anterior Cruciate Ligament Repair by Arthroscopy)	Outpatient
Knee Replacement- Joint Replacement Surgery	Inpatient
Laparoscopic Removal of Ovaries and/or Fallopian Tubes	Outpatient
Laparoscopic Tubal Block or Tubal Ligation	Outpatient
Leg - MRI Lower Limb	Diagnostic Radiology
Lithotripsy - Fragmenting of Kidney Stones	Outpatient
Lower Limb with Joint - MRI	Diagnostic Radiology

Procedure Name	Category
Mammography - Analog	Diagnostic Radiology
Mammography Digital	Diagnostic Radiology
Nasal/Sinus- Corrective Surgery Septoplasty	Outpatient
Nasal/Sinus- endoscopy Sinus Surgery	Outpatient
Pelvis - CT Scan Pelvis	Diagnostic Radiology
Shoulder - Rotator Cuff Repair (using Arthroscopy)	Outpatient
Shoulder - Surgical examination (using Arthroscopy)	Outpatient
Stomach - CT Scan Abdomen	Diagnostic Radiology
Stomach - Upper Digestive Tract examination (using Endoscopy with Biopsy)	Diagnostic/Outpatient
Stomach - Upper Digestive Tract examination (using Endoscopy)	Diagnostic/Outpatient
Tonsils and Adenoids - Removal, under age 12	Outpatient
Urethra and Bladder Scope	Diagnostic/Outpatient

How to Avoid Provider Identification Errors

For Claims Involving NPI and Tax ID Number

Below are reminders to help you reduce the number of WEBV040 and WEBV042 claims errors displayed when claim data (or information) does not match information registered with Florida Blue.

Billing Provider Section

This section is used to provide information regarding the billing provider for services rendered. It should match the name written on the check or electronic funds transfer from Florida Blue.

- **OPTION 1:** If you are registered as a group provider (PA, LLC, etc.) with Florida Blue and you want to bill as a group provider, enter the appropriate group name, Tax ID number and the group NPI (type 2).
- **THE MATCH**: Group Name matches Group NPI matches Group Tax ID
- **OPTION 2:** If you are registered as an individual provider with Florida Blue and you are billing as an individual provider, please enter your name, Social Security Number and your individual NPI (type 1).
- **THE MATCH:** Individual Name matches Individual NPI matches Individual Social Security Number

Rendering Provider Section

This section is used to provide information regarding who performed the services. It is the provider who actually sees the patient.

- **OPTION 1:** If you billed as an organization (PA, LLC, etc.) list the name of the rendering individual provider and the rendering individual NPI.
- **OPTION 2:** If you billed as an individual, do not list a rendering provider. This would be redundant as the billing individual would be the same as the rendering individual. Submitting redundant information can cause a different provider correctable error.

Below is an example to assist you in understanding the appropriate entry of billing and rendering provider information to reduce the number of returned claims. Additional HIPAA 5010 reference information can be found on our website at www.floridablue.com under the Provider tab and by selecting "Get Ready for 5010."

Billing as a Group Provider OPTION 1

If you are billing as a group provider (PA, LLC, etc.), the NPI entered must be the Group NPI (type 2) along with the appropriate Tax ID number for the group.

Please note that the Billing Section is for the entity BILLING for the services. The Rendering Provider Section is for the provider who PERFORMED the services.

Correct Entry (THE MATCH):

This example shows how the information submitted matches data registered with Florida Blue. The Group Name matches Group NPI which matches Group Tax ID number and all match Florida Blue provider files.
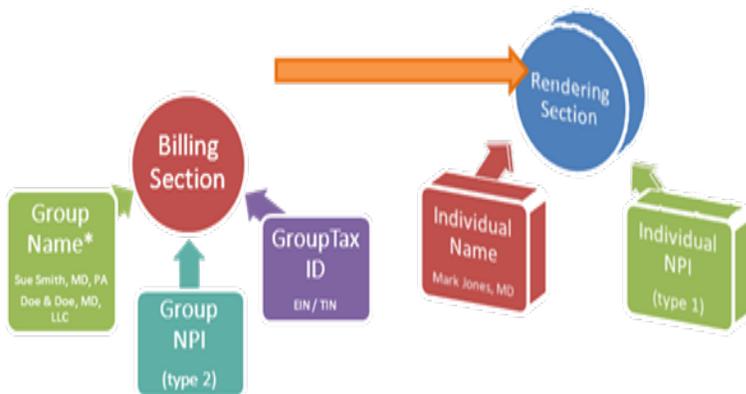
Incorrect Entries (THE MISMATCH):

Below are examples of information that will result in a mismatch of data causing a WEBV040 provider correctable error ultimately resulting in a delay in payment. The mismatch is highlighted in red.
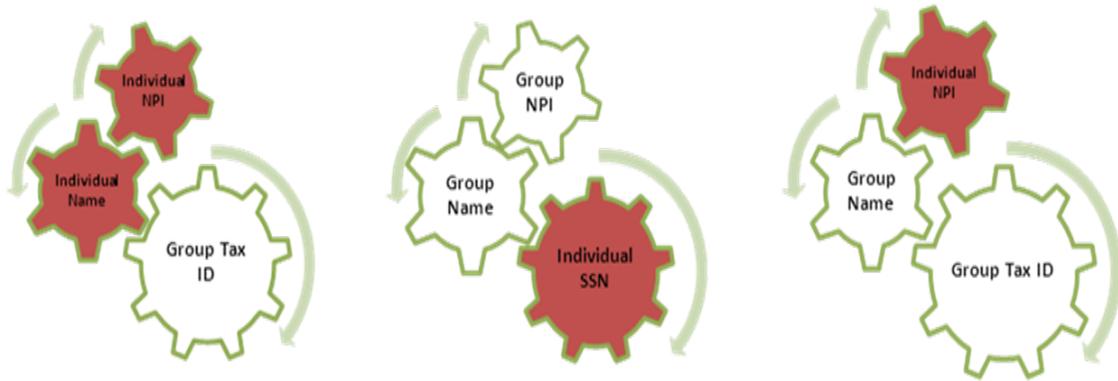
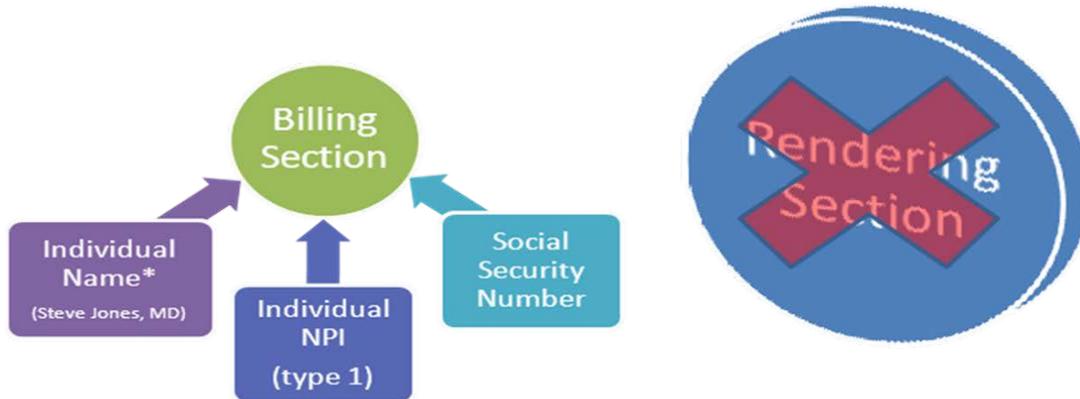Remember: Group Name = Group NPI = Group Tax ID Number

To confirm how you are registered with Florida Blue, please call the Provider Contact Center at (800) 727-2227, select option 5, and then option 2. If you would like to register a different Tax ID number, please complete the Provider Information Update Form (sections 1 and 6.) A completed IRS confirmation letter must be included.

Billing as an Individual Provider Option 2

If you are billing as an individual provider, the NPI must be the individual NPI (type 1) along with the appropriate Social Security Number. Do not enter a provider at all in the rendering section when the billing and rendering provider is the same person. Submitting redundant information can cause a different provider correctable error.

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Correct Entry (THE MATCH):

This example shows how the information entered matches data registered with Florida Blue. Individual Name matches Individual NPI matches Individual Social Security Number.

Incorrect Entries (THE MISMATCH):

Below are examples of information entered that will result in a mismatch of data causing a delay in payment. The mismatch is highlighted in red.
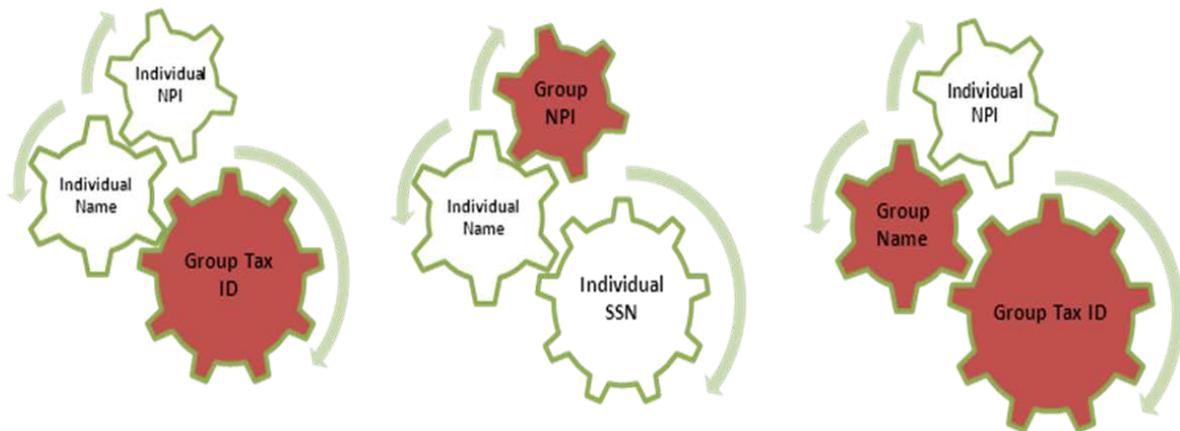
REMEMBER: Individual Name = Individual NPI = Individual Social Security Number

To confirm how you are registered with Florida Blue, please call the Provider Contact Center at (800) 727-2227, select option 5, and then option 2. If you would like to register a different Tax ID number, please complete the Provider Information Update Form (sections 1 and 6.) A completed IRS confirmation letter must be included.

Ancillary Billing with NPI

If ancillary providers have a Florida Blue (Blue Cross Blue Shield of Florida, Inc.) and/or Florida Blue HMO (Health Options, Inc.) Provider agreements that do not require the registration of employed health care providers then only the billing provider information should be populated on the claim.

If the Florida Blue (Health Options, Inc.) provider agreement requires registration of employed health care providers, then the rendering and billing NPI should be billed appropriately on claims.

The following is a sample of necessary provider billing information required on the CMS-1500 or electronic version 837:

Ancillary provider with registered employed health care providers:

- Billing provider NPI and Tax ID in 33 (loop 2010AA)
- Rendering provider NPI in 24J (loop 2310B & 2420A)

Ancillary Provider with no registered employed health care providers:

- Billing provider NPI and Tax ID in 33 (loop 2010AA)
- Rendering provider left blank

Florida Blue NPI Attribute Matrix and Legend

Legend	
R	Required
S	Situational
Blank	Not Available
IG	Implementation Guide
FB	Florida Blue
A	Availity

Florida Blue NPI Attributes Matrix
NPI Attribute Requirements

Claims	NPI Institutional			NPI Professional			Taxonomy Institutional			Taxonomy Professional			EIN (Tax ID) Institutional			EIN (Tax ID) Professional			Zip + 4 Digit Institutional			Zip + 4 Digit Professional		
PROVIDER TYPES	IG	FB	A	IG	FB	A	IG	FB	A	IG	FB	A	IG	FB	A	IG	FB	A	IG	FB	A	IG	FB	A
Billing Provider	R	R	R	R	R	R	S	R	R	S	R	R	R	R	R	R	R	R	R	R	R	R	R	R
Pay To																			S	S	S	S	S	S
Rendering Provider	S	R	R	S	R	R				S	R	R												
Referring Provider	S	S	S	S	S	S																		
Ordering Provider				S	S	S																		
Supervising Provider				S	R	R																		
Servicing Facility	S	S	S	S	S	S													R	R	R	R	R	R
Attending	S	R	R				S	R	R															
Operating	S	R	R																					
Other Operating Physician	S	R	R																					
Purchase Service Provider				S	S	S																		

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NPI Attributes Technical Information

837 Professional Claims	NPI				
Provider Type	IG	FB	Loop	Segment	Data Element
Billing Provider	R	R	2010AA	NM1	9
Rendering Provider	S	R	2310B 2420A	NM1	9
Referring Provider	S	S	2310A 2420F	NM1	9
Ordering Provider	S	S	2420E	NM1	9
Supervising Provider	S	R	2310D 2420D	NM1	9
Purchase Service Provider	S	S	2420B	NM1	9
Servicing Facility	S	S	2310C 2420C	NM1	9

837 Institutional Claims	NPI				
Provider Type	IG	FB	Loop	Segment	Data Element
Billing Provider	R	R	2010AA	NM1	9
Rendering Provider	S	R	2310D 2420C	NM1	9
Referring Provider	S	S	2310F 2420D	NM1	9
Servicing Facility	S	S	2310E	NM1	9
Attending	S	R	2310A	NM1	9
Operating	S	R	2310B 2420A	NM1	9
Other Operating	S	R	2310C 2420B	NM1	9