Manual for
Physicians and Providers

CLINICAL OPERATIONS,
CARE AND UTILIZATION MANAGEMENT
SECTION

CLINICAL OPERATIONS PROGRAMS.. 3
Concurrent Review 3
Case Management 3
Facility/Physician 3
Chronic Conditions - Disease Management 4
High Risk Maternity Program.. 4
Neonatal Intensive Care Unit.. 4
Pediatric Care Program.. 4
PATCH (PHYSICIAN ASSESSMENT, TREATMENT, AND CONSULTATIONS AT HOME) SERVICES... 4
Attending physician:.. 5
Directly to PATCH Program providers: 6
PATCH – Contracted Provider Responsibilities:.................................... 7
Program Recap: 8
UTILIZATION MANAGEMENT FOR OUR PRODUCTS........................... 9
Utilization Management by Commercial Product & Network Table 10
MEDICARE UTILIZATION MANAGEMENT.. 22
Coverage Determinations for BlueMedicareSM Members 24
Utilization Management Table by Network/Product..26
MEDICAL AND SPECIALTY PHARMACY UTILIZATION MANAGEMENT 34
PROVIDER ADMINISTERED DRUG PROGRAM (PADP) AND PHYSICIAN ADMINISTERED DRUG VOLUNTARY PREDETERMINATION FOR SELECT SERVICES (VPSS).................... 34
Procedures for Ordering Physicians..35
Magellan Rx Management Access Information....................................35
Website Access..35
Magellan Rx Management Request Timeframes....................................35
Claim Submission Information 36
Drug Units 36
Diagnosis 36
Modifiers 36
Specialty Pharmacy Medications-Self and Physician Administered.................................37

Clinical Operations Programs

Our Clinical Operations Programs involve a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates services that meet identified health needs of members. Decisions are subject to the terms and conditions of the member's benefit.

Concurrent Review
We may, but are not required to review inpatient stays and other health care treatment programs. The review is conducted solely to determine whether or not we should continue coverage and/or payment for services.

Case Management
Case Management involves early identification of members with serious complex or catastrophic health problems to facilitate cost effective, quality health care to meet the member's needs.

The services are voluntary and offered at no additional cost. For assistance, contact Case Management/Disease Management.

Case Management - FEP Case Management services are provided to FEP members who may need services such as SNF, LTAC, or acute inpatient rehabilitation facility services), contact FEP Care Coordination and follow the prompts.

Note: FEP does not provide coverage for SNF and LTAC services. For assistance, contact FEP Case Management.

Facility/Physician

The facility is responsible for providing clinical information to support coverage decisions. As part of discharge planning we may, but are not required, to assist in identifying health care resources, which may be available in the member's community following an inpatient stay.

You are required to contact and provide us with clinical information to support discharge decisions under the following circumstances:

- An extension of the approval is needed. Contact must be made prior to the expiration of the approved days.
- The member's discharge plan indicates transfer to an alternative level of care is appropriate.
- The member has a complex plan of treatment that includes home health services, home infusion therapy, total parenteral nutrition and/or multiple or specialized durable medical equipment identified prior to discharge.

Note: Facilities are defined as hospital, LTAC, acute rehabilitation facility and SNF.

Chronic Conditions - Disease Management
Chronic Condition Management involves identification and management of chronic conditions such as diabetes, COPD, asthma, congestive heart failure and cardiovascular disease and assists members in meeting appropriate healthcare goals.

The services are voluntary and offered at no additional cost. For assistance, contact Case Management/Disease Management.

Delegated Case Management for Behavioral Health Services
The management of behavioral health services for Florida Blue and Florida Blue HMO members, including Case Management, is delegated to New Directions Behavioral Health.

High Risk Maternity Program
This program is designed to assist members who have been diagnosed as high risk pregnancy through a supportive, consultative condition management process and is available to facilitate discharge planning for high-risk mothers who can be safely managed in a lower level of care. For assistance, contact Case Management/Disease Management.

Neonatal Intensive Care Unit
This program is designed for families of newborns admitted to the Neonatal Intensive Care Unit for extended services. The case manager supports the family through the transition of care into the home setting and performs discharge planning at the earliest appropriate time. For assistance, contact Case Management/Disease Management.

Pediatric Care Program
This program is designed to provide case management services to members under age 19 with serious or complex health care problems or specific rare or core chronic condition diagnosis. Our Case Managers outreach to parents and caregivers to provide information, education, resources, and access to services to help address the specific care needs of our member. Case Managers facilitate access to resources to optimize available health plan benefits, assists members to gain optimum health, and improves functional capability in the right setting and in a cost effective manner. For assistance, contact Case Management/Disease Management.

PATCH (Physician Assessment, Treatment, and Consultations at Home) Services

This program applies only to Physician Groups and/or Physicians who have specifically agreed to be PATCH Program providers. Florida Blue reserves the right, in its sole discretion, to determine which Physician Groups and/or Physicians may be PATCH Providers.

PATCH is a program designed for Florida Blue members that are homebound, either permanently or temporarily. The PATCH Program promotes access to physicians who can stand in for the member's own treating physicians while the individual is temporarily or permanently unable to access such care. Physicians are contracted to provide comprehensive care in the home setting to high risk members who would not otherwise have access to such care. The program is not a replacement for the member's regular physician.

This program is available for all lines of business except FEP and Blue Card Host. Services are currently available in the following counties:

West Network - Hernando, Pasco, Hillsborough, Pinellas, Manatee, Hardee, Sarasota, Desoto, Highlands, Glades, Hendry, Collier, Lee and Charlotte

Central Network - Flagler, Volusia, Sumter, Polk, Lake, Orange, Brevard, Seminole, Osceola

South Network - Dade, Broward, and Palm Beach

Physicians in the above counties who are interested in becoming a PATCH Program provider may submit a letter of interest by going to the Florida Blue website.

Members are referred into the program in several ways, below is a list of how members are referred.

Attending physician:

1. Attending physician contacts the Florida Blue Case Management Program by calling (800) 955-5692 Option 4
    - Florida Blue Case Management Program takes basic information and forwards the referral to the local PATCH Program provider
2. Attending physician contacts a PATCH Program provider directly
    - The PATCH Program provider contacts the Florida Blue Case Management Program by calling (800) 955-5692 Option 4
3. A Florida Blue case manager in conjunction with a Florida Blue medical director reviews the referral for appropriateness in the Patch Program.
4. The Patch Provider schedules an initial visit with the member.

Directly to PATCH Program providers:

1. All referrals made directly to a PATCH Program provider such as, but not limited to
   - member self-referral
   - hospital discharge planner
   - attending physician
   - hospitalist-should be forwarded to the Florida Blue Case Management Program by calling (800) 955-5692 Option 4

Once a member has been referred by a PATCH Program provider or attending physician, the member is evaluated for voluntary participation in the PATCH Program:

2. A Florida Blue case manager in conjunction with a Florida Blue medical director assesses the referral for appropriateness in the Patch Program
3. The Florida Blue case manager obtains the member's voluntary participation agreement and enrolls the member in the PATCH Program
4. The PATCH Provider schedules an initial visit with the member.

By agreeing to become a PATCH Provider, it is agreed that if services are provided to a member who has not been approved by Florida Blue to be in the PATCH Program or if services are not provided in accordance with the treatment plan, then compensation for any Covered Services will be at 100% of Medicare allowable for the locality in which the services were rendered. It is acknowledged that given system limitations, it may be necessary to apply such rate after the initial payment upon audit by Florida Blue. This constitutes an amendment to any of PATCH Provider's participating provider agreements with Florida Blue and/or Health Options.

Appropriate members to refer to the program are those confined to their residence if home care by a physician is medically necessary. The following are examples of members who might be appropriate for this program:

- Acute or chronic illness with a complex medical condition and/or multiple co-morbidities, who are at risk for unplanned emergency room or inpatient admission.
- Appropriate hospital discharge follow-up that may require close oversight or management.
- Members who would benefit from a face-to-face consultation with a physician to reinforce compliance with the treatment plan or to review other options, including advanced directives, palliative care and end of life discussion when appropriate.

The Florida Blue medical director may speak directly with the PATCH Program provider when there is a question about the medical necessity for home care by a physician.

PATCH – Contracted Provider Responsibilities:

- Acknowledges the Florida Blue PATCH Program referral and schedules the home care evaluation within 24 hours after receiving initial visit approval to determine member appropriateness for the PATCH Program.
- Completes the comprehensive member physical/psychosocial assessment, establishes a treatment plan and provides Florida Blue Case Management the results of this initial visit with recommendations within 48 hours.
- Obtains approval from Florida Blue Case Management and/or Florida Blue Medical Director to execute the member's treatment plan through the PATCH Program, and provides oversight to the care and treatment plan.
- Initiates contact with the Florida Blue member's attending/physician of record, apprises the physician of the PATCH referral, copies the member's current primary physician and the Florida Blue Case Management on the treatment plan, and communicates ongoing clinical status updates in writing to keep the primary physician and Florida Blue Case Management aware of clinical status.
- In medically appropriate circumstances, provides member education pertaining to their treatment options and alternative care paths available for potentially improving quality of life at any stage, including discussion of end-of-life, if applicable. Home visit discussion may include:
    - Advance Directives
    - Risk factor management
    - Therapy review & options
    - Medication review
    - Treatment Plan Compliance
    - Disease specific education
    - Preventative Care
    - Caregiver education
    - Social services needs
- When ordering diagnostic services and other home health services (as appropriate), uses current participating Florida Blue ancillary providers
- Bills for utilizing only the following codes physician E&M services provided to the member in a private home:
    - New patients: 99342, 99343,99344, 99345
    - Established patients: 99347, 99348, 99349, 99350
    - Prolonged service: 99354

It is the intent of this program that the compensation for the above codes constitutes compensation for all services rendered in connection with the visit. No additional codes will be billed without prior written consent from Florida Blue. If additional codes are billed and paid, such additional amounts will be recoverable by Florida Blue upon audit.

- Participates in peer to peer clinical reviews with the Florida Blue Medical Director as needed
- Participates in quality review discussions and meetings with Florida Blue Medical Director as needed
- Cooperates with all PATCH Program and Florida Blue audit processes including, but not limited to:
    - medical appropriateness assessment
    - proper notification procedures
    - adherence to treatment plan

Audit results may lead to a reduction in reimbursement rate and the member will be held harmless.

Program Recap:
The PATCH Program requires ongoing communication with mutual agreement between Florida Blue and contracted PATCH providers, for initial and ongoing member participation and physician services in the home setting. The physician can order a variety of services, if needed, from the current participating ancillary provider network. The program is not a replacement for the member's regular physician. Member participation in the PATCH Program is voluntary, and PATCH Providers notify the Florida Blue Case Management Program by calling (800) 955-5692 Option 4.

Utilization Management for Our Products

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 (Blue Cross and Blue Shield of Florida, Inc.) and its affiliate, Florida Blue HMO (Health Options, Inc.) you are required to comply fully with medical management programs. Check Availity® for your member's specific guidelines.

This includes but is not limited for the following:

- 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 our medical management onsite or telephonic nurse reviewer.
- Permitting access to the member's medical information.
- Including our medical management nurse in discharge planning discussions and meetings.
- Providing a plan of treatment, progress notes, and other clinical documentation as required.
- HMO products do not have out-of-network benefits in most circumstances, so all services by out-of-network providers will still require prior authorization review.
- HMO members require authorization through New Directions Behavioral Health for behavioral health services, including inpatient, outpatient, partial hospitalization, IOP and substance abuse rehabilitation.
- FEP requires prior approval for select outpatient services except but may not limited to the following:
    - Outpatient intensity-modulated radiation therapy (IMRT) – Prior approval is required for except when related to the treatment of head, neck, breast, or prostate cancer.

Note: Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required for IMRT treatment of brain cancer.

- Hospice care- Prior approval is required except when Medicare Part A is the primary payer.
- Self-administered retail or specialty pharmacy services- Prior authorization is required.
- FEP Basic Option, FEP Standard Option and FEP Blue Focus preferred providers must be used with the following exceptions:
    - Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport;
    - Professional care provided at Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons;
    - Laboratory and pathology services, X-rays, and diagnostic tests billed by Non-preferred laboratories, radiologists and outpatient facilities;
    - Services of assistant surgeons;
    - Special provider access situations; or
    - Care received outside the United States, Puerto Rico, and the U.S. Virgin Islands

Utilization Management by Commercial Product & Network Table

Service	Network – Product	Contractual Obligation
Advanced Imaging (CT Scans, MRIs/MRAs, PET Scans, Nuclear Medicine) **FEP Plans** do not require authorizations for Advanced Imaging. ***See (Appendix-B) for list of procedures or visit www.RadMD.com for more detailed clinical guidelines.***"	BlueCare – HMO	Authorizations are required and should be requested from NIA.
	BlueChoice - Preferred Patient Care Traditional - PPS/PHS	Authorization, certification, or notification is not required.
	BlueOptions - NetworkBlue BlueSelect	Request authorizations from NIA.
	Fully Insured, ACA Compliant Large Group BlueChoice – Preferred Patient Care Traditional – PPS/PHS	Request authorizations from NIA.
	State Employee PPO - PPC/PPO	Authorization, certification, or notification not required
Ambulance	BlueCare - HMO	Authorization required for non-emergency transport only.
Behavioral Health Services Authorizations are required and should be requested from New Directions Behavioral Health **Note**: Psychologists, mental health clinicians, LCSWs, LMHCs, MFTs, and BCBAs are behavioral health services provided to Florida Blue members.	BlueCare - HMO BlueSelect FEP Blue Focus – PPC/PPO	**Inpatient:** All inpatient psychiatric and substance abuse admissions require authorization by the admitting facility. **Outpatient:** Behavioral health services are managed, no authorization is required. Partial hospitalization, IOP and Substance Abuse Rehabilitation: Require authorizations and must be coordinated.
	BlueChoice - Preferred Patient Care BlueOptions - NetworkBlue Traditional - PPS PHS Certification should occur within one business day of admission.	**Inpatient:** Certification required for psychiatric and substance abuse facilities. **Outpatient:** Authorization may be required for some members.

Service	Network – Product	Contractual Obligation
Behavioral Health Services	FEP Basic - PPC/PPO FEP Standard - PPC/PPO	**Inpatient:** Preadmission certification required for psychiatric and substance hospitals. $500 penalty applies if precertification is not obtained. **Outpatient:** Prior approval is not required to receive mental health and/or substance abuse to include partial psychiatric, intensive outpatient or outpatient professional or outpatient facility care. ***Note***: Does not include coverage for applied behavioral analyst. Please access Availity® for services and network information.
Birthing Centers	BlueCare – HMO	Submit authorization requests electronically through Availity®
Cardiology Services (Non-Emergent) ****Effective on or after July 9, 2018***	Large Group (Non-grandfathered): Blue Options – Network Blue BlueCare – HMO BlueChoice – PPO Small Group ACA: Blue Options – Network Blue BlueCare – HMO BlueSelect Individual ACA: Blue Options – Network Blue BlueCare – HMO BlueSelect myBlue HMO	Non Emergent Cardiology Services (other than services rendered in the emergency room or an inpatient setting) are subject to a prior authorization requirement. This includes both the professional and institutional components of such services. Failure to obtain an authorization prior to rendering the services may result in a denial of the claim. AIM Billable Cardiology Codes Utilization Review is performed by AIM Specialty Health: AIM's portal can be accessed through Single Sign On capability within Availity®® or directly: www.aimprovider.com/cardiology or by calling 1-844-423-0879 ***Note****:* This program will NOT apply to members who are covered through self-insured administrative services only (ASO) plans nor will it apply to any members of other Blue Cross and/or Blue Shield Plans that may access the above networks through the BlueCard® program.

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Service	Network – Product	Contractual Obligation
Chemotherapy Refer to Medical Pharmacy list for the specific drugs that requires prior approval.	State Employee PPO BlueOptions – Network Blue BlueChoice – PPO BlueCare – HMO BlueSelect FEP	Prior approval required if participating in the PADP. Refer to Magellan RX Management
Clinical Education	BlueCare - HMO	Authorization required.
Chiropractic Chiropractic providers participating in the American Specialty Health, ASH network should call 800-972-4226. All services are subject to medical necessity review.	Blue Care – HMO Blue Options Blue Select myBlue Simply Blue Miami Dade Blue Exchange Products	The following functions will be managed by American Specialty Health (ASH): • Provider Contracting & Credentialing • Utilization Management • Claims Processing • Provider Appeals • Coordination of Benefits
Dialysis	BlueCare - HMO	Authorization required. Submit authorization requests electronically through Availity®.
Durable Medical Equipment Florida Blue's exclusive provider for these services must be requested through CareCentrix at 877-561-9910, by fax at 877-627-6688, or online through the CareCentrix web portal.	BlueCare - HMO BlueChoice - PPC/PPO BlueOptions - NetworkBlue	Authorization is required for all DME and MS needs.
	Blue Select	For Blue Select and Blue Care members based on medical appropriateness for a condition, some DME and medical supplies do not require a prior authorization when a participating provider supplies the items. See our standing authorization section.
Home Health/Home Infusion Florida Blue's exclusive provider for these services must be requested through CareCentrix at 877-561-9910, by fax at 877-627-6688 or online through the CareCentrix web portal. **Note** – For providers not included in CareCentrix network, authorization is required through Florida Blue.	BlueCare - HMO BlueChoice - PPC/PPO BlueOptions - NetworkBlue Traditional - PPS/PHS	Authorization is required for Home Health needs. All authorizations are to be requested through CareCentrix
	BlueSelect - BlueSelect	Authorization is required for all Home Health services.

Service	Network – Product	Contractual Obligation
Hospice If the services on the claim are not the same as those authorized, the claim will be held for review of more information. For Blue Select, if timely notification is not made by a facility of an inpatient admission or if no notification is made, a financial penalty may be imposed of 20 percent of the total claim for an episode of care that would have otherwise been due to the inpatient facility under the Agreement then in effect if provider notification had been provided (regardless of payment methodology defined within the provider Agreement) up to a maximum of $500, for each BlueSelect member's inpatient claim received without a notification.	BlueCare – HMO	Authorization required Hospice services require submission of the request and a treatment plan (hospice plan) by the member's PCP or participating provider for review and approval by Florida Blue (Health Options, Inc.)
	BlueSelect Submit notifications electronically through Availity®	Notification required.
Hospice Prior approval is not required for pre-hospice enrollment benefits.	FEP Basic - PPC/PPO FEP Standard - PPC/PPO FEP Blue Focus – PPC/PPO	Approval is required for the following services: •Traditional home hospice care •Continuous home hospice care •Inpatient hospice care
	State Employee PPO - PPC/PPO	No authorization, certification or notification required.
Hyperbaric Oxygen Hyperbaric oxygen treatment (99183, A4575, C1300) requires authorization.	BlueCare - HMO	Submit authorization requests electronically through Availity®
Infertility Treatment Submit authorization requests electronically through Availity®	BlueCare - HMO BlueSelect BlueOptions – Network Blue (Qualified Health Plans – Individual & Group)	Authorization required when benefit coverage is available.
	BlueOptions - NetworkBlue	Authorization, certification, or notification is not required. However, Voluntary Predetermination for Select Services is available for select services where Florida Blue has a Medical Policy.

Service	Network – Product	Contractual Obligation
Injectable Medication Submit authorization requests electronically through Availity®	BlueCare - HMO BlueSelect BlueOptions – Network Blue (Qualified Health Plans – Individual & Group)	Authorization required Refer to Medical Pharmacy list for the specific drugs that requires prior approval.
	BlueChoice -Preferred Patient Care Traditional - PPS/PHS	Certification required for acute care hospitals and psychiatric/substance abuse facilities, including a partial hospitalization program.
Inpatient - Acute and Long Term Acute Care (LTAC) Submit authorization requests electronically through Availity® Newborn admissions require separate authorization from mother if either baby stays after mother is discharged, admission will be billed with DRG 789-793, or if mother is not insured through Florida Blue. Certification for un planned admissions should occur within one business day of admission. Certification for planned admissions should occur five business days prior to date of service.	BlueCare - HMO	Authorization required
	Blue Options-Network Blue Skilled Nursing Facility (SNF) with access to select high-cost medication through Ambient Healthcare and Coram Infusion Specialty for members admitted for sub-acute care.	Participating facilities are required to notify Florida Blue of member admissions to SNFs before close of business of the day following admission. Florida BlueCare Coordinators review the SNF admission, either onsite or telephonically, and collaborate with the facility staff to assist with identifying coverage options available for members through focused condition, discharge planning and ancillary services as needed.
	BlueChoice Traditional - PPS/PHS	Certification required for acute care hospitals and acute rehabilitation.
Inpatient - Acute and Long Term Acute Care (LTAC) Submit authorization requests electronically through Availity® Newborn admissions require separate authorization from mother if either baby stays after mother is discharged, admission will be billed with DRG 789-793, or if mother is not insured through Florida Blue.	BlueSelect Notification of unplanned admissions should be received as soon as possible, but no later than the end of the next business day. For changes from outpatient to inpatient status, an inpatient notification must be made at the time the member is admitted. Planned services: Notifications should be submitted five working days prior to the date of service.	**Penalty:** If timely notification is not made by a facility of an inpatient admission or if no notification is made, a financial penalty may be imposed of 20 percent of the total claim for an episode of care that would have otherwise been due to the inpatient facility under the Agreement then in effect if provider notification had been provided (regardless of payment methodology defined within the provider Agreement) up to a maximum of $500, for each BlueSelect member's inpatient claim received without a notification.

Service	Network – Product	Contractual obligation
Inpatient - Acute and Long Term Acute Care (LTAC) Submit authorization requests electronically through Availity® Newborn admissions require separate authorization from mother if either baby stays after mother is discharged, admission will be billed with DRG 789-793, or if mother is not insured through Florida Blue.	FEP Basic - PPC/PPO FEP Standard - PPC/PPO FEP Blue Focus – PPC/PPO $500 penalty applies if precertification is not obtained *Except members using benefits under the Blue Distinction Centers for transplant benefit Acute inpatient rehabilitation and LTAC services require approval by contacting the FEP Care Coordination.	Pre-admission certification is required for acute care and psychiatric and substance abuse facilities. Submit certifications electronically through Availity®. Exceptions are: • Maternity admissions for routine delivery (routine is within 48 hours vaginal delivery/96 hour cesarean • Admissions outside the U.S. and Puerto Rico • When other insurance, including Medicare A, is paying primary* • When Medicare A is primary and member is confined to VA hospital
Inpatient - Acute and Long Term Acute Care (LTAC) Submit authorization requests electronically through Availity® Newborn admissions require separate authorization from mother if either baby stays after mother is discharged, admission will be billed with DRG 789-793, or if mother is not insured through Florida Blue.	State Employee PPO - PC/PPO	Preadmission certification required for acute care, LTAC and psychiatric and substance hospitals. Penalty is 20 percent of the allowed amount, not to exceed $500. Exceptions are: • When Medicare A is primary • Out of country hospitals
Laboratory In most instances, referral should be made to Quest Diagnostics or Dermpath Diagnostics. The preferred lab for anatomical pathology services in Florida is AmeriPath. Submit authorization requests electronically through Availity® In Office Laboratory List	BlueCare - HMO Quest Diagnostics is Florida Blue's preferred laboratory provider. BlueChoice - PPC/PPO BlueOptions - NetworkBlue State Employee PPO - PPC/PPO Traditional - PPS/PHS Quest Diagnostics is Florida Blue's preferred laboratory provider. BlueSelect -	If unable to use Quest Diagnostics, then a prior authorization is required. Services obtained at other facilities other than to Quest Diagnostics, Dermpath Diagnostics or AmeriPath may result in higher out-of-pocket cost for the member. Laboratory services are managed under exclusive arrangement with Quest Diagnostics.

Service	Network – Product	Contractual obligation
Office and Outpatient Diagnostic Tests Submit authorization requests electronically through Availity® . ***See* (Appendix-B) *for list of procedures or visit* www.RadMD.com *for more detailed clinical guidelines.*"**	BlueCare - HMO	Authorization required if done in outpatient setting. **Exception:** Participating physicians have standing authorizations for approval of certain diagnostic tests. Click here to view a list of codes.
Ophthalmology South Florida	BlueCare - HMO	Ophthalmology for South Florida (Broward, Martin, Miami-Dade, Okeechobee, Palm Beach and St. Lucie counties) – members and/or physicians should coordinate services with EMI.
Oral Maxillofacial Submit authorization requests electronically through Availity®	BlueCare FEP Basic - PPC/PPO FEP Standard - PPC/PPO FEP Blue Focus – PPC/PPO	Authorization required **Prior approval is required for:** •Outpatient surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth •Surgical correction of congenital anomalies
Orthotic / Prosthetic Authorization is required for all DME and Orthotic/Prosthetic needs provided by providers participating in the CareCentrix network.	All products Submit authorization requests electronically through Availity® CareCentrix at 877-561-9910, by fax at 877-627-6688, or online through the CareCentrix web portal.	**Providers that do not participate in CareCentrix network** may not require prior authorization, but are eligible for a Voluntary Predetermination for Select Services for a covered service determination for equipment and supplies.
Outpatient Rehabilitation	BlueCare - HMO	No authorization required

Service	Network – Product	Contractual obligation
Outpatient Hospital Services (Includes 23 Hour Observation Care) Submit authorization requests electronically through Availity®	**BlueCare - HMO** All outpatient psychiatric and substance abuse admissions must be coordinated through New Directions Behavioral Health. **Note:** Labor check billed under revenue codes 720, 721 and 729 do not require authorization.	Authorization required
	BlueChoice - PPC/PPO BlueOptions - NetworkBlue Traditional - PPS/PHS	Notification is required for observation status admissions and all status changes from observation to inpatient. Other outpatient services do not require authorization or notification. Please access Availity® for services and network information.
Pain Management Submit authorization requests electronically through Availity®	BlueCare – HMO	Authorization required
Pharmacy - Provider Administered Drug Program applies (PADP) Magellan RX Management Self-administered drugs may not be covered in the office except those used in the treatment of diabetes, cancer, conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis which are covered.	FEP Basic - PPC/PPO FEP Standard - PPC/PPO	Prior approval required for certain medications. Refer to Caremark for a current Rx drug prior approval list.
	• BlueCare - HMO • BlueSelect PADP applies	Benefits vary by member contract and may contain medical cost share. Refer to PADP Medication List to determine drugs that require prior authorization
	• BlueChoice - PPC/PPO • BlueOptions – Network Blue PADP applies NetworkBlue	Benefits vary by member contract and may contain medical cost share. •Hemophilia program – managed by Caremark Refer to PADP Medication List to determine drugs that require prior authorization • Voluntary Predetermination for Select Services is available
	State Employee PPO - PPC/PPO	PADP applies Managed by Caremark

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Service	Network – Product	Contractual obligation
Radiation & Oncology *Effective on or after May 1, 2016*	 Large Group (Non-grandfathered): Blue Options – Network Blue BlueCare – HMO BlueChoice – PPO Small Group ACA: Blue Options – Network Blue BlueCare – HMO BlueSelect Individual ACA: Blue Options – Network Blue BlueCare – HMO BlueSelect myBlue HMO	Any radiation oncology services any radiation oncology services (other than services rendered in the emergency room or an inpatient setting) provided to members enrolled in the following plans are subject to a prior authorization requirement. This includes both the professional and institutional components of such services. Failure to obtain an authorization prior to rendering the services may result in a denial of the claim. AIM Billable Radiation Oncology Codes Utilization Review is performed by AIM Specialty Health: AIM's portal can be accessed through Single Sign On capability within Availity®® or directly: http://aimspecialtyhealth.com/CG-RadiationOncology.html or by calling 1-844-423-0879 **Note**: This program will **NOT** apply to members who are covered through self-insured administrative services only (ASO) plans nor will it apply to any members of other Blue Cross and/or Blue Shield Plans that may access the above networks through the BlueCard® program.
	FEP	**FEP Members are managed by Florida Blue** Prior approval is required for all outpatient intensity-modulated radiation therapy (IMRT) except when related to the treatment of head, neck, breast, anal cancer or prostate cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required for IMRT treatment of brain cancer.

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Service	Network – Product	Contractual obligation
Sleep Study - Please contact Care Centrix Sleep Management Program at (855) 243-3326 See (Appendix C) for list of procedures. BlueCare HMO plans do not require referrals when seeing participating specialists.	Fully Insured BlueCare HMO (Health Options) My Blue Fully Insured, ACA-Compliant Blue Options – Network Blue Fully Insured, ACA-Compliant Blue Select Fully Insured, ACA Compliant Large Group BlueChoice – Preferred Patient Care Traditional – PPS/PHS Self-Funded groups are excluded from this delegated vendor Program	Florida Blue has implemented a mandatory pre-service review/prior authorization program for sleep and titration studies. For a list of group #'s exempt from Sleep Management Solutions please click here. CareCentrix Sleep Study Prior Auth Fax Request Form
Spine Care Spine Care procedures: Authorizations will be handled by National Imaging Associates. See (Appendix E) for list of procedures.	Fully Insured Blue Care HMO (Health Options) My Blue-Fully Insured, ACA-Compliant Blue Options – Network Blue Fully Insured, ACA-Compliant Blue Select Fully Insured, ACA Compliant Large Group BlueChoice – Preferred Patient Care Traditional – PPS/PHS Self-Funded groups are excluded from this delegated vendor Program (Groups Excluded from Delegated Vendor UM Programs)	Authorizations will be handled by National Imaging Associates (NIA). See Appendix E for a list of procedures Cosmetic, plastic, or reconstructive surgery is subject to medical necessity review. *(Continued on next page)* Link to Request Authorizations through NIA www.RadMD.com

Service	Network – Product	Contractual obligation
Skilled Nursing Facility Select Medication Program The voluntary Select Medication Program is available to participating SNFs with access to select high-cost medication through Ambient Healthcare and Coram Infusion Specialty for members admitted for sub-acute care. See the SNF program for specific details. Contact our UM department at 1-877-205-2583	Blue Care HMO Blue Select **Blue Select Penalty:** If timely notification is not made by a facility of an inpatient admission or if no notification is made, a financial penalty may be imposed of 20 percent of the total claim for an episode of care that would have otherwise been due to the inpatient facility under the Agreement then in effect if provider notification had been provided (regardless of payment methodology defined within the provider Agreement) up to a maximum of $500, for each BlueSelect member's inpatient claim received without a notification.	Authorization required. Submit authorization requests electronically through Availity®
	BlueChoice PPO Traditional PPS/PHS	Notification of an admission is not required but may be entered electronically through Availity®
	Blue Options PPO	Participating facilities are required to notify Florida Blue of member admissions to SNFs before close of business of the day following admission.

Service	Product	Contractual Obligation
Surgical Procedures	Blue Care HMO	Authorization required Submit authorization requests electronically through Availity®
	FEP Basic-FEP Standard FEP Blue Focus FEP Basic-FEP Standard FEP Blue Focus	Prior approval must be obtained for the following surgical services if they are performed in an outpatient setting: • Surgery for morbid obesity • Surgical correction of congenital anomalies • Surgery to correct accidental injuries to jaw, cheek, lips, tongue, roof and floor of mouth Advanced Benefit Determination is available for select services; see our Voluntary Predetermination for Select Services in the Utilization Management section. The provider should fax their request and all necessary medical and member information (i.e., procedure, diagnosis codes, supporting documentation) to 1-866-441-1569. If the provider submits their request to FEP via mail, once received, our Customer Service Department will forward it to the appropriate location to be reviewed.
	Blue Choice Blue Options State Employee-PPO Traditional	Authorization, certification or notification is not required. However, Voluntary Predetermination for Select Services may be required.

Service	Product	Contractual Obligation
Therapy Physical/Occupational/Speech Language Pathologists **Children must be under 18 years of age, or still in high school, and have been diagnosed as having Autism at 8 years of age or younger. **Children must be under 18 years of age, or still in high school, and have been diagnosed as having Down syndrome.	Blue Care HMO	No Authorization Required **Note:** Large group only- Therapy for Autism and Down Syndrome must continue to be covered even after outpatient therapy limits are met.
Transplant Services (excluding office visit)	Blue Care HMO	Authorization required Submit authorization requests electronically through Availity®
	Blue Choice Blue Options Traditional PPS/PHS	Transplant services may be subject to conditions and/or limitations of the member's contract. To determine whether a proposed transplant may be covered, the physician should contact our Utilization Management department.
	FEP Basic/Standard/ Blue Focus	Prior approval required; contact our UM department and follow the appropriate prompts.
	State Employee PPO	Prior Benefit determination must be obtained for all transplants except Kidney or Cornea. Contact our Utilization Management department to determine if benefit applies.
Urgent Care	ALL standard Small Group & Large Group products	Urgent Care Centers-INN and OON services will apply the same Copay/Coinsurance. The INN Deductible will apply to INN services and the OON Deductible will apply to OON Services.

Medicare Utilization Management

Florida Blue has 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 Florida Blue, 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 medical necessity (as defined in the Member Handbook or Evidence of Coverage) is solely for the purpose of determining coverage of 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 us, you are required to fully comply with all medical management programs.

This includes:

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

BlueMedicare HMO, BlueMedicare PPO or BlueMedicare Group PPO, authorization/notification requirements apply, as these are Medicare replacement policies without Original Medicare as primary coverage.

Prior approval is required except when Medicare Part A is the primary payer.

Note: UM pages are designed to provide general guidelines for a particular line of business, but are not specific to member contracts. Check Availity® at Availity®.com for specific guidelines for your Florida Blue patients.

Note: If the member's primary coverage is Original Medicare (as in a Medicare Supplement member), then authorization/notification is not required for participating physicians and providers.

Coverage Determinations for BlueMedicare^SM 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 Florida Blue Medicare Advantage members (BlueMedicare^SM), Florida Blue 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 "local" or regional Medicare contractor can establish which services are reasonable and necessary within its jurisdiction and, therefore, covered as a Medicare benefit.

Procedures 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 provider may be liable and may not bill the member for the service.

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.
- First Coast Service Options - Medicare LCD at http:\\medicare.fcso.com for information about LCD guidelines.
- For Florida Blue evidence-based Medical Policies use our Medical Coverage Guidelines on our Florida Blue website.

As with 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®[1] 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; this also applies to referrals to other participating and non-participating providers.

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 by Florida Blue 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.

If a provider inappropriately refers a member for services to a participating or non-participating provider, we may not pay for the referral outside of payment agreements, and the provider who referred 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.

NOTE: A notification of a referral from a Primary Care Physician is 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.

Utilization Management Table by Network/Product

Submit authorization requests electronically through Availity®

Service	Network - Product	Contractual Obligation
Advanced Imaging (CT Scans, MRIs/MRAs, PET Scans, Nuclear Medicine) ***See (Appendix-B) for list of procedures or visit www.RadMD.com for more detailed clinical guidelines.*** ”	Medicare Advantage HMO Medicare Advantage PPO	Authorizations are required and should be requested from NIA for CT scans, MRAs, MRIs and cardiovascular office and outpatient procedures. Refer to the NIA section for additional details.
Ambulance	Medicare Advantage HMO Medicare Advantage PPO	Authorization is required for non-emergency transport only.
Behavioral Health Services Required authorizations must be coordinated through New Directions Behavioral Health. If a participating provider fails to comply with New Directions Behavioral Health's utilization management programs for behavioral health services, they may be penalized 100 percent of the payment and the member must be held harmless. If the authorization/certification/notification is denied as “non-covered” services, the member is held financially responsible.	Medicare Advantage HMO	**Inpatient:** All inpatient psychiatric and substance abuse admissions require authorizations and must be coordinated through New Directions Behavioral Health. Inpatient authorizations are coordinated with New Directions Behavioral Health by the admitting facility **Outpatient**: Behavioral health services are managed under an exclusive arrangement with New Directions Behavioral Health and must be coordinated through New Directions Behavioral Health. **Partial hospitalization, IOP and substance abuse rehabilitation:** Requires authorization and must be coordinated through New Directions Behavioral Health.
	Medicare Advantage PPO **Note:** Certification should occur within 24 hours of admission. Planned admissions- five business days prior to date of service Partial hospitalization: Authorization is not required.	**Inpatient:** Notification is required for inpatient admissions to psychiatric and substance abuse facilities. **Outpatient:** Prior authorization is not required.

Service	Network - Product	Contractual Obligation
Cardiology Services (Non-Emergent) ***Effective on or after July 9, 2018***	Medicare Advantage HMO Medicare Advantage PPO	Non Emergent Cardiology Services (other than services rendered in the emergency room or an inpatient setting) are subject to a prior authorization requirement. This includes both the professional and institutional components of such services. Failure to obtain an authorization prior to rendering the services may result in a denial of the claim. AIM Billable Cardiology Codes Utilization Review is performed by AIM Specialty Health: AIM's portal can be accessed through Single Sign On capability within Availity®® or directly: http://www.aimproviders.com/cardiology/ or by calling 1-844-423-0879
Chemotherapy Notification of a referral from a Primary Care Physician is required for ALL BlueMedicare HMO products when the member requires treatment from specialists, urgent and emergency care does not require a referral.	Medicare Advantage HMO	Referral required for all hematology/oncology office visits. Authorization in addition to the referral for required for select Chemotherapy drugs. Refer to Medical Pharmacy list Refer to Magellan RX Management for select chemotherapy drugs managed by Magellan Rx Management
	Medicare Advantage PPO	Authorization required for any chemotherapy services. Refer to Magellan RX Management for select chemotherapy drugs managed by Magellan Rx Management
Chiropractic	Medicare Advantage HMO Medicare Advantage PPO	Authorization is not required.
Clinical Education	Medicare Advantage HMO Medicare Advantage PPO	Authorization is not required.
Dialysis	Medicare Advantage HMO Medicare Advantage PPO	Authorization is not required. Authorization is not required.

<table>
<tr><th>Service</th><th>Network - Product</th><th>Contractual Obligation</th></tr>
<tr><td>Durable Medical Equipment
You should also refer to CMS Guidelines and to Florida Blue's Medical Policies (Medical Coverage Guidelines) for specific requests. DME or medical supplies that exceed the quantity limitations in the Medical Policies (Medial Coverage Guidelines) are subject to prior authorization.

Authorization requests to CareCentrix 877-561-9910, by fax at 877-627-6688 online through the CareCentrix web portal at https://www.carecentrixportal.com</td><td>Medicare Advantage HMO
Medicare Advantage PPO

For providers contracted with CareCentrix.

DME or medical supply items should be accessed through CareCentrix.

CareCentrix will arrange for services to be rendered by one of its participating providers or when appropriate, refer the member to the applicable Florida Blue HMO DME, or medical supply provider that can render the needed services.</td><td>Authorization is required.
For providers not contracted with CareCentrix; authorizations are required.

Requests should be submitted five working days prior to the date needed or within 24 business hours of the physician's order.

Payment will be denied if authorization is not obtained.

If extenuating circumstances exist that delayed this process, the provider should advise Florida Blue.</td></tr>
<tr><td rowspan="2">Home Health/Home Infusion

Home Health, home infusion are managed under an exclusive arrangement with CareCentrix for Florida Blue HMO. Home health and home infusion services must be accessed through CareCentrix.

CareCentrix will arrange for services to be rendered by one of its participating providers or when appropriate, refer the member to the applicable Florida Blue HMO home health provider that can render the needed services.</td><td>Medicare Advantage HMO</td><td>Authorization is required.

An example of services that CareCentrix may refer to a MA HMO provider includes, but is not limited to continuous nursing care beyond four hours</td></tr>
<tr><td>Medicare Advantage PPO</td><td>Authorization is required for Home Health needs.</td></tr>
</table>

Service	Network - Product	Contractual Obligation
Hospice Patients must enroll in a Medicare-certified hospice program to be eligible for Medicare hospice benefits. The hospice program covers hospice services and other Part A and Part B services related to the terminal prognosis and are paid for by Original Medicare. Covered services when a terminal prognosis has been given include: • Drugs for symptom control and pain relief • Short-term respite care • Home care Other Plan-covered services, including Part A and Part B services not related to the terminal prognosis, are covered either by Original Medicare or the Plan depending on whether you are a network provider with the member's Medicare Advantage plan.	BlueMedicare HMO BlueMedicare PPO	For hospice care or other Part A or Part B services that are related to the terminal prognosis, submit claims to Original Medicare for processing and payment. For other Plan-covered services, including Part A and Part B services not related to the terminal prognosis: If you are **NOT** a network provider under the member's Medicare Advantage plan, submit claims to Original Medicare rather than our Plan. The member's cost-sharing would be the applicable cost-sharing under Original Medicare. If you are a network provider under the member's Medicare Advantage plan, submit claims to the Medicare Advantage plan. The member's cost-sharing would be the applicable amount under the Medicare Advantage plan.
Hip & Knee **Effective January 1, 2019-----------** Authorizations will be handled by National Imaging Associates. See (Appendix E) for list of procedures.	Medicare Advantage HMO Medicare Advantage PPO BlueCare HMO My Blue	Authorizations will be handled by National Imaging Associates (NIA). See (Appendix E) for a list of procedures Cosmetic, plastic, or reconstructive surgery is subject to medical necessity review. Link to Request Authorizations through NIA:www.RadMD.com
Inpatient Psychiatric	Medicare Advantage HMO Medicare Advantage PPO	Authorization is required.

Service	Network - Product	Contractual Obligation
Inpatient - Acute and Long Term Acute Care (LTAC) **Note:** Submit authorization requests electronically through Availity®	Medicare Advantage HMO Medicare Advantage PPO	Authorization required Certification required for acute care hospitals and acute rehabilitation. Certification should occur within one business day of admission. Certification for planned admissions should occur five business days prior to date of service.
Outpatient Diagnostic Tests Includes test provided in the office. Medicare Advantage participating physicians have standing authorizations for approval of certain diagnostic tests. Medicare Advantage Participating physicians have standing authorizations for approval of certain diagnostic tests. Click here to view a list of codes.	Medicare Advantage HMO	Prior authorization may be required for certain services, please check eligibility and benefits through Availity®. Referral from a Primary Care Physician may be required for treatment from specialists, with the exception of urgent and emergency care providers.
	Medicare Advantage PPO	Prior authorization may be required for certain services, please check eligibility and benefits through Availity®.
Ophthalmology South Florida Ophthalmology for South Florida (Broward, Martin, Miami-Dade, Okeechobee, Palm Beach and St. Lucie counties) – members and/or physicians should coordinate services with EMI.	Medicare Advantage HMO	Routine eye exams, diabetic retinal exams and eye glasses do not require a referral and are administered through Davis Vision.
Oral Maxillofacial Submit authorization requests electronically through Availity®	Medicare Advantage HMO Medicare Advantage PPO	Authorization required
Outpatient Hospital Services (Including 23 hour Observation Care)	Medicare Advantage HMO .	Authorization required. All outpatient psychiatric and substance abuse admissions must be coordinated through New Directions Behavioral Health.

Service	Network - Product	Contractual Obligation
Outpatient Hospital Services (Including 23 hour Observation Care) **Outpatient Rehabilitation**	Medicare Advantage PPO Medicare Advantage HMO	Authorization required. All outpatient psychiatric and substance abuse admissions must be coordinated through New Directions Behavioral Health. Authorization is required.
Outpatient Rehabilitation **Pain Management**	Medicare Advantage PPO Medicare Advantage HMO	Authorization is required. Authorization is required.
Pain Management **Pharmacy –** Provider Administered Drug Program (PADP) Magellan RX Management	Medicare Advantage HMO Medicare Advantage PPO Benefits vary by member contract and may contain medical cost share. This information can be found in Availity®. Member medical cost share exists for covered Medicare B care drugs administered in the office, which is 20 percent coinsurance.	A Prior authorization may be required for certain services, please check eligibility and benefits through Availity®. Refer to PADP Medication List to determine drugs that require prior authorization through Magellan Rx Management
Pharmacy - Self-Administered	Medicare Advantage HMO Medicare Advantage PPO	• Refer to the Medication Guide to determine drugs that require prior authorization. • Hemophilia program – managed by Caremark. Refer to the Medication Guide for Medicare Eligible for drugs covered under this plan. • Some self-administered drugs require prior authorization as identified in the Medication Guide for Medicare Eligible. Review Medication Guide for specifics. • Refer to the Medicare Pharmacy section for additional pharmacy program details. • Some self-administered drugs require prior authorization as identified in the Medication Guide. Review the Medication Guide for specifics. • Click here for information regarding the differences Part B and Part D.

Service	Network - Product	Contractual Obligation
Radiation & Oncology Therapy ***Effective on or after May 1, 2016***	Medicare Advantage HMO Medicare Advantage PPO	Any radiation oncology services any radiation oncology services (other than services rendered in the emergency room or an inpatient setting) provided to members enrolled in the following plans are subject to a prior authorization requirement. This includes both the professional and institutional components of such services. Failure to obtain an authorization prior to rendering the services may result in a denial of the claim. AIM Billable Radiation Oncology Codes Utilization Review is performed by AIM Specialty Health: AIM's portal can be accessed through Single Sign On capability within Availity®® or directly: http://www.aimproviders.com/cardiology/ or by calling 1-844-423-0879
Radiology	Medicare Advantage HMO Medicare Advantage PPO	Authorization is required.
Skilled Nursing Facility The voluntary Select Medication Program is available to participating SNFs with access to select high-cost medication through Ambient Healthcare and Coram Infusion Specialty for members admitted for sub-acute care.	Medicare Advantage HMO Medicare Advantage PPO	Authorization is required.
Spine Care Spine Care procedures: Authorizations will be handled by National Imaging Associates. See (Appendix E) for list of procedures.	Medicare Advantage HMO Medicare Advantage PPO	Authorizations will be handled by National Imaging Associates (NIA). See Appendix E for a list of procedures Cosmetic, plastic, or reconstructive surgery is subject to medical necessity review. Link to Request Authorizations through NIA:www.RadMD.com
Surgical Procedures	Medicare Advantage HMO Medicare Advantage PPO	Authorization is required.

Service	Network - Product	Contractual Obligation
Therapy Physical Therapy Occupational Therapy Speech Language Pathology	Medicare Advantage HMO	Authorization is required for physical/occupational therapy.
	Medicare Advantage PPO	
Transplant Services The facility performing the services must meet specific CMS criteria.	Medicare Advantage HMO	Authorization is required.
	Medicare Advantage PPO	Authorization is required.
Transportation Non-Emergency This benefit provides non-emergency transportation for routine medical/dental appointments, to the pharmacy, for ongoing care arrangements, and to Florida Blue Centers with a clinician in select counties.	Medicare Advantage HMO This benefit is available in select counties .	Authorization is not required. Benefit includes 48 trips per calendar year. A trip is counted as one way; a round trip counts as two trips. Members must call LogistiCare at 1-855-875-519 to make a reservation.

Medical and Specialty Pharmacy Utilization Management

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. Outlined below is our UM programs and their applicable products.

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.

Please reference the Medical Pharmacy Drug List for a list of drugs that will require prior approval.

- FEP Basic - PPC Prior approval required for certain medications. Refer to Caremark for a current Rx drug prior approval list.
- FEP Standard - PPC Prior approval required for certain medications. Refer to Caremark for a current Rx drug prior approval list.
- FEP Blue Focus - PPC Prior approval required for certain medications. Refer to Caremark for a current Rx drug prior approval list.

Provider Administered Drug Program (PADP) and Physician Administered Drug Voluntary Predetermination for Select Services (VPSS)

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®. Please use the Provider Administered Drug Program Medication List.

****Note:** Depending upon the member's benefits drugs not covered under PADP may require prior authorization through Florida Blue. **

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.

Note: 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. Details of this pre-service review process are listed below. Requirements for the pre-service review process are applicable to the following products:

- HMO (BlueCare HMO, SimplyBlue, My Blue, BlueMedicare HMO)
- PPO (BlueChoice, BlueMedicare PPO, BlueOptions, BlueSelect, GoBlue, Miami-Dade Blue)
- State Employees' PPO Plan
- Traditional

The PADP pre-service review process is unavailable for certain members including BlueCard, BlueMedicare PFFS, Medicare supplement and FEP. It is also not available for members whose primary coverage is Medicare Part B

The PADP pre-service review process is unavailable for certain members including BlueCard, BlueMedicare PFFS, Medicare supplement and FEP. It is also not available for members whose primary coverage is Medicare or the secondary insurance coverage is Florida Blue.

Procedures for Ordering Physicians

1. Prior to requesting a pre-service review verify member eligibility and benefits through Availity® or contact the Provider Contact Center.
2. To expedite the process, have the following information ready:
   - Name and office phone number of the in-office physician
   - Member name and ID number
   - Requested medical pharmacy drug(s)
   - Anticipated start date of treatment (if known)
   - Patient weight and/or body surface area
   - Dosing information and frequency
   - Diagnosis
   - Past therapeutic failures (if applicable)
3. If requested, be prepared to fax the following documents:
   - Clinical notes
   - Pathology reports
   - Relevant lab test results

Magellan Rx Management Access Information

For routine pre-service requests access Magellan Rx Management's provider self-service at http://ih.magellanrx.com and click on the physician tab. and click on the physician tab. Web access is available 24 hours a day and 7 days a week. Magellan Rx Management also provides a toll-free call center for pre-service requests at (800) 424-4947. The call center is available Monday through Friday, 8:00 a.m. to 6:00 p.m. Eastern Time.

For expedited or urgent pre-service requests please call the Magellan call center at (800) 424-4947. Magellan Rx Management's website should not be used for expedited or urgent requests. Magellan Rx Management can accept multiple pre-service requests on their website (http://ih.magellanrx.com) or during a phone call.

Website Access

If you need assistance with establishing a unique user name and password for your office use the secure online website tool at http://ih.magellanrx.com and click on Help. Your office administrator will be provided access and then be able to set up a username for each individual user in your office.

Magellan Rx Management Request Timeframes

The provider must contact Magellan Rx Management for a pre-service review determination prior to the service date but no later than the day of the service being requested. Urgent requests will be completed by Magellan Rx Management within 72 hours from receipt of the request. Non-urgent requests will be completed within seven (7) days from receipt of the request.

Claim Submission Information
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.

Specialty Pharmacy Medications-Self and Physician Administered

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. Outlined below are Florida Blue's UM programs and their applicable products.

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.

***Refer to Appendix A - Medical Pharmacy for a full listing of Medical Pharmacy drugs requiring prior authorization.

Program Description	Document Links
Pharmacy Benefit Programs	
Medication Guides A listing of brand and generic prescription drugs that may be covered; less than one of our pharmacy plans. For complete coverage details, please have your patients refer to their Pharmacy Program Endorsement.	Select the Applicable Medication Guide under the following link: Medication Guides
Formulary Exception -Formulary Exception for Plans with Closed Formulary Benefit	Formulary Exception Physician Fax Form
Responsible Quantity Program- Responsible Quantity is an initiative to ensure that prescription drug coverage reflects drug manufacturers' and FDA dosing guidelines. Prior authorization must be obtained by provider as set forth in the Medication Guide.	Responsible Quantity Drug List Quantity Limit Physician Fax Form
Responsible Step Program Responsible Steps is an initiative to ensure the use of a designated or prerequisite drug(s) first in order for coverage of the drug included in the Responsible Steps program. Prior authorization must be obtained by provider as set forth in the Medication Guide.	Responsible Step Program Description and Physician Fax Form Responsible Steps for Medical Pharmacy Program Information and Authorization Forms
Generic Copay Waiver Program	First Fill Switch from Brand to Select Generic Drug Copay Waiver Program Information

<table>
<tr><th>Program Description</th><th>Document Links</th></tr>
<tr><td colspan="2">A list of commonly prescribed drugs where a member may discuss with their physician the opportunity to switch to a less costly generic alternative. Florida Blue will waive the initial co-pay when a member switches to a generic alternative. This link provides a list of the medications covered under the program. This program may not apply to all Florida Blue Pharmacy products.</td></tr>
<tr><th colspan="2">Pharmacy Benefit Programs</th></tr>
<tr><td>Medications Not Covered List

The pharmacy benefit may not cover select medications. Some of the reasons a medication may not be covered are:

•The medication has been shown to have excessive adverse effects and/or safer alternatives

•The medication has a preferred formulary alternative or over-the-counter (OTC) alternative

•The medication is no longer marketed

•The medication has a widely available/distributed AB rated generic equivalent formulation

•The medication has been has been repackaged - a pharmaceutical product that is removed from the original manufacturer container (Brand Originator) and repackaged by another manufacturer with a different NDC.</td><td>Drugs that are Not Covered List</td></tr>
</table>

Program Description	Document Links
Specialty Pharmacy	
Self-Administered Specialty List	Self-Administered Specialty Drug List
Coverage varies by product. Verify member benefits before providing services.	Refer to the Medication Guide
Provider-Administered Specialty List	Provider-Administered Specialty Drug List
Preferred Specialty Pharmacy Enrollment (Order) Forms	CVS Caremark Form Prime Specialty Pharmacy Form CVS Caremark Hemophilia Form
Prior Authorization	
Prior Authorization- Prior Authorization assures that specific clinical criteria are met in order for coverage of the drug included in the Prior Authorization program.	Prior Authorization Programs
Physician Administered Drug Program (PADP) For physicians who supply and bill and participate in the PADP 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.	Magellan RX Management
Individual Under 65 Prior Authorization Program For members who enrolled within Florida Blue Individual Qualified Health Plan (QHP) in 2014 require prior authorization for a variety of Medical Pharmacy drugs Based on the place of service and/or who is providing, an authorization must be obtained by the following entities for the drug services.	Refer to Appendix A - Medical Pharmacy for a full listing of Medical Pharmacy drugs requiring prior authorization. Prior Authorization is required for all Medical Pharmacy services excluding: • Emergency Room • Urgent Care • Inpatient -covered under Inpatient Authorization/Notification as required by product.
Specialty Pharmacy provider ('Just in Time Services'/'Drug Replacement") - Coordinate with CVS Caremark or Prime Specialty Pharmacy	

Program Description	Document Links
In-State Physicians buying and billing	
	ICORE (refer to PADP Provider Manual Section) for the select drugs referenced.
	Availity®®1 or contact Florida Blue at 1-800-727-2227 for drugs not included within the PADP section.
Home Health/Home Infusion	
	CareCentrix (CCX) - if rendering provider is part of CCX Network
	Florida Blue - Availity®®1 or contact Florida Blue at 1-800-727-2227
	Drug administered in Outpatient Hospital setting - Availity®®1 or contact Florida Blue at 1-800-727-2227
	Out of State Providers - Availity®®1 or contact Florida Blue at 1-800-727-2227
	All Other (including Non-Participating Providers) - Availity®®1 or contact Florida Blue at 1-800-727-2227
* Benefits vary according to the terms of the member contract. Verify benefits prior to rendering services.	