Florida Blue

Your local Blue Cross Blue Shield

Manual for Physicians and Providers

Claim Submission

Billing Guidelines

Submitting a Claim

This section of the *Manual for Physicians and Providers* explains certain aspects of the claim process.

Definitions and Claim Application

Site of Service

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

Substitute Physicians

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

Advanced Non-Physician Practitioners (Physician Extenders)

Advanced Non-Physician Practitioner (Physician Extender) is defined as: Advanced Practice Registered Nurse (APRN), Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS), Physician Assistants (PA), and Registered Nurse First Assistant (RNFA). They are health care providers who practice either in collaboration with or under the supervision of a physician.

Advanced Non-Physician Practitioner (Physician Extender) services should be billed with the extender's NPI or Florida Blue number in block 24J on the CMS-1500 as the rendering provider.
Florida Blue requires a separate claim for each rendering provider. A single service rendered by two or more providers for the same member on the same date of service must be billed with the provider who performed the substantive portion of the service in block 24J. Illustrative examples are listed below:

- If the Physician Extender performs the history and physical and the physician evaluates the patient's medical condition, orders tests, and develops a treatment plan, then the service should be billed with the physician as the rendering provider.
- If the Physician Extender performs the history and physical, evaluates the patient's medical condition, orders tests, and develops the treatment plan and the physician enters the examination room to confirm the diagnosis and treatment plan, then the service should be billed with the Physician Extender as the rendering provider.

Advanced Non-Physician Practitioner (Physician Extender) should not submit claims under the following circumstances:

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

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

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

Surgical first assist services by a licensed physician extender should be reported with modifier AS appended to the procedure code and billed by the employing physician group, employer, or clinic. The physician extender NPI or Florida Blue provider number must be utilized in block 24J as the rendering provider.

Florida Blue payment policy will determine which surgical procedure codes are eligible for reimbursement for an assistant at surgery. The reimbursement percentage is determined by the Florida Blue payment policy and the provider's contract.

Types of Claim Submissions

Paper Claims CMS 1500 and UB-04

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

- Centers for Medicare & Medicaid Services *www.cms.gov*
- Florida Hospital Association *www.fha.org*
- National Uniform Billing Committee *www.nubc.org*
- National Uniform Claim Committee *www.nucc.org*

CMS-1500

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

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

Pharmacy Claim (Medical)

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

Drug Units

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

Unclassified drug codes

(J3490, J3590, J9999, J1599, etc.) must always be billed with the drug name, NDC and NDC units. The NDC should be provided in field 24G on a CMS-1500 and in loop 2410 segment LIN on an electronic 837 Professional claim submission. If you have additional questions on how to bill NDCs for electronic claim submission, please refer to Provider Manual, Billing Guidelines for Drug Services - NDC Quantity section 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.

Modifier

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.

UB-04

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

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

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

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

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

Electronic Claims

Electronic Claim Submissions allow providers to safely submit and track HIPAA-compliant electronic claims to us via Availity® without manual intervention.
Electronic claims must be filed through Availity® or send your claims through a billing service or clearinghouse to transmit to Availity® and then route to us. Availity® edits transactions according to the HIPAA-AS requirements. A number of payer specific edits are also performed before routing transactions to Florida Blue.

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

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

Electronic Claims

- FL Blue Electronic Transaction Companion Documents found here.

Claim (835) and Encounter Data Submissions

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

Inclusion of a complete and accurate list of diagnosis codes associated with the member at the time of the encounter, including any chronic conditions not necessarily treated at the time of the encounter, will help ensure correct coding of the encounter. Additionally, it helps us match patients with appropriate care and disease management programs, and ensure members are properly classified by risk programs. We encourage you to purchase current copies of CPT, HCPCS, and ICD-10-CM code books.

It is particularly important to accurately code your claim because the level of coverage may very under the member's benefit plan for different services. You must submit a claim and/or encounter, regardless of whether you have collected the member's copayment, deductible or coinsurance at the time of service.

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

- Verify coverage. Groups often have changes in their health insurance benefit plans. Make re-verifying coverage through Availity®.
- Submit the entire member ID number including prefix. Submit the member ID number not the member's Social Security number. Remember to correct your billing system when there are changes. The 835 electronic remittance advices will indicate when a member's identification (ID) number is processed with a different identifier than was submitted.
- Complete all claim entry fields. To receive proper reimbursement, the claim information must be completed in its entirety. Incomplete or inaccurate information will result in a claim denial.
- Medicare providers may not balance bill qualified Medicare beneficiaries for Medicare cost share amounts. See October 2016 Bulletin on our Florida Blue site.
- Enter the date of onset to report dates of injury, accident, first symptom, etc.; as required, based on current coding guidelines.
- Use valid codes. CPT, HCPCS, and ICD codes are updated quarterly. Make sure you or your billing service is using the most up-to-date codes.
- Report an unlisted code only if unable to find a procedure code that closely relates to or accurately describes the service performed. Unlisted codes require documentation and therefore cannot be submitted electronically.
- Use diagnosis codes that indicate a general medical exam when billing for "preventive" health screening exams. Claims for these services will be denied if other diagnosis codes are used.
- Submit modifiers affecting reimbursement in the first and second position on claims. A procedure code modifier, when applicable, provides important additional information about the service performed. When multiple modifiers are necessary for a single claim line, modifiers should be submitted in the order that they affect payment.
- Submit multiple procedures on one claim. All procedures performed on the same date of service, by the same provider for the same patient should be submitted on one claim.
- Submit all applicable diagnosis codes. Code to the highest level of specificity possible. Most 3-digit codes require a fourth or fifth digit.
- Include the National Provider Identifier (NPI) for rendering physician and billing physician or group. Both the CMS-1500 and UB-04 include fields for the NPI.

Prompt Claims Processing/Timely Filing Limits

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

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

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

Medical Records

Documentation Requirements

All healthcare entities and providers are required to keep medical records. These records are legal documents that serve clinical needs and to substantiate the services and items billed on the claim submitted. Incomplete, insufficient, or illegible records may result in denials or payment delays.

All records should be complete and legible and require the following information:

- Reason for encounter
- Relevant history
- Findings
- Tests ordered and test results
- Date of service
- Assessment and impression of diagnosis
- Plan of care
- Legible identity of observer
- Progress notes to support medical necessity of service performed
- Documentation should support that the rendering/billing provider indicated on the claim is the healthcare professional providing service.
- Documentation should clearly identify the patient by their full name (first and last), patient DOB, and Medical Record or Account Number.
- Records should substantiate services performed and the required level of care provided.

Signature and Date Requirements

Florida Blue requires that medical record documentation include the date and the handwritten or electronic signature of the individual who provided/ordered the service(s). The signature for each entry must be legible and should include the practitioner's first and last names and credentials. Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process). Missing or illegible signature may result in denials or payment delays.

Special Notes for Electronic and Digital Signatures

Electronic signatures typically contain:

- date and timestamps
- printed statements, e.g,'electronically signed by,' or 'verified/reviewed by'
- the practitioner's full name and preferably a professional designation

Digital signatures are electronic written signatures typically generated by special encrypted software that is intended to authenticate the identity of the person signing.

The responsibility and authorship related to the signature should be clearly defined in the record. The electronic system/process should be secure, allowing sole usage or password protection for each user.

Electronic and digital signatures are not the same as ‘auto-authentication’ or ‘auto-signature’ systems, some of which do not mandate or permit the provider to review an entry before signing. Indications that a document has been ‘Signed but not read’ are not acceptable.

Amendments, Corrections and Delayed Entries in Medical Documentation

All services provided are expected to be documented in the medical record at the time they are rendered. In the event certain entries related to services provided are not properly documented, the documentation will need to be amended, corrected, or entered after rendering the service.

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to Florida Blue containing amendments, corrections or addenda must:

- Clearly and permanently identify any amendment, correction, or delayed entry
- Clearly indicate the date and author of the amendment, correction, or delayed entry
- Leave all original content, without deletion
- Make updates in a timely manner, generally recognized by CMS as within 90 days of the encounter.

Paper Medical Records

When correcting a paper medical record, these principles are accomplished by: Using a single line strike through so the original content is still readable, and the author of the alteration must sign and date the revision.

Amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record. Amendments or delayed entries to paper records may be initialed and dated if the medical record contains evidence associating the provider’s initials with their name. For example, if the initials match the first and last name of the practitioner documented elsewhere in the medical records including typed or written identifying information, the entry will be accepted.

Electronic Health Records (EHR)

Records sourced from electronic systems containing amendments, corrections or delayed entries must: Distinctly identify any amendment, correction, or delayed entry, and provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

Medical Record Cloning

The word 'cloning' refers to documentation that is worded exactly like previous entries. This may also be referred to as 'cut and paste', ‘copy and paste’, or 'carried forward.' Cloned documentation generally occurs when using a preprinted template or an electronic record.

It is not expected that a patient would have the same exact problem/symptoms requiring the exact same treatment on every encounter; or that records for different patients would have identical entries in their documentation. The medical record must contain documentation showing the differences and the needs of

the patient for each visit or encounter. Simply changing the date on the EHR without reflecting what occurred during the actual visit is not acceptable.

Requests for Medical Records

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

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

Corrected Claims

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

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

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

Paper corrected claim:

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

Electronic corrected claim:

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

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

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

7 – Replacement of Prior Claim

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

8 – Void/Cancel of Prior Claim

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

Supplemental Claims

For Additional Diagnosis Codes (Non-institutional)

A supplemental claim for additional diagnosis is a claim filed by a provider, in addition to the initial claim, that allows for reporting of additional diagnosis codes. The latest version of the non-institutional claim form (CMS 1500) allows the submission of twelve diagnoses per claim.

Newer practice management systems are able to accommodate the submission of twelve diagnosis codes. Older practice management systems may only accommodate four. Florida Blue considers all case data when performing analysis for HEDIS/STARS, Risk Adjustment, and other performance reports.

The "Supplemental Claims for Additional Diagnosis" bulletin will guide providers with practice management software limitations through the process of submitting these supplemental claims.

Overview

For practice management systems allowing less than twelve diagnosis codes:

- Initial claim must include Evaluation & Management CPT code
- Submit a second (supplemental) claim using procedure code 99080
- Submit $.00 or $.01 charge based on your software requirement
- Electronic claims must include frequency code "0." Do not use frequency type 7.
- Enter one clinical ICD-10 code from initial claim in position one and all other ICD-10 codes in positions two through twelve.

  Note: medical documentation must be updated to support the additional (supplemental) codes.

Please refer to the Supplemental Claims for Additional Diagnosis bulletin for additional instructions and information.

Important Reminders

Timely filing

- All claim submissions have a 180-day timely filing limit
  - You must submit any supplemental claims within 180 days of the original E&M service

Capitated Arrangements

- If you are under a capitated payment arrangement do not submit date span claims for office services (Place of Service 11)
  - CMS requires documentation, coding, and claim submissions to align to each individual date of service and face to face encounter

Claim Status, Inquiry and Rejected

Claim Status

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

Claim Inquiry

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

Rejected Claims

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

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

If you have additional questions or need to verify your current contractual agreements require you to participate in the PADP, contact Network Management.

HIPAA Version 5010 Updates and Helpful Tips

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

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

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

- Billing Provider Address: You must use a physical street address for your Billing Provider Address. Version 5010 does not allow for use of a P.O. Box address for either professional or institutional claim formats. You can still report a P.O. Box as a pay-to address.
    - ZIP Code: You need to include a complete 9-digit ZIP code for the billing provider and service facility location. You should work with your software vendor or clearinghouse to make sure that your system captures the full 9-digit ZIP code.
- Florida Blue Proprietary ID: This number can no longer be submitted for electronic claims; the taxonomy and NPI are now required fields.
- Present on Admission (POA) Indicator: A POA indicator is now submitted in conjunction with diagnosis codes.
- Ambulance Services (pick-up/drop off): A valid postal zone or zip code is required when billing for ambulance or non-emergency transportation services.
- Anesthesia Services: Minutes are required for anesthesia claims.
- Coordination of Benefits (COB):
    - The Other Payer allowed amount can no longer be reported for electronic claims.
    - The Rules of Balancing now include the COB section of the claim.
- First Name: First name is not required when this information is not available/not known.
- Outpatient Claims: Outpatient claims now require a new segment "Patients Reason for Visit".
- Diagnosis Qualifiers: Indicators have been added to distinguish between ICD-09 and ICD-10 codes in preparation for ICD-10 implementation.

Billing Guidelines

This section of the Manual contains billing guidelines for various provider types. It was developed with consideration of the latest coding methodologies from several sources, including but not limited to:

- Coding descriptions and instructions as identified in the latest release of the American Medical Association Current Procedural Terminology (AMA CPT)
- Healthcare Common Procedure Coding System (HCPCS) developed by the Centers for Medicare and Medicaid Services (CMS), 19th edition (IPG)
- Applicable laws in the state of Florida.

Some of the information contained in the Manual may not apply to you if your services are being accessed through a management company or vendor arrangement (e.g. – Lucet Behavioral Health or CareCentrix). Refer to your management company or vendor policies and procedures.

Payment Policies provide information on payment methodologies, payment rules, and how Florida Blue (Blue Cross and Blue Shield of Florida, Inc.) and its affiliate, Florida Blue HMO (Health Options, Inc.) apply those rules to your claim. Refer to the Payment Policies on our website for detailed information.

Coding a Claim

Coding a Facility Claim Procedure, Modifier and Diagnosis Codes

A critical element in claims filing is the submission of current and accurate codes to reflect the services provided. Correct coding is essential for correct reimbursement. We have applied procedure code edits to outpatient claims for our Medicare Advantage members since 2008.

Complete and accurate procedure code, modifier, and diagnosis code usage at the time of billing ensures accurate processing of correct coding initiative edits. We can only use the primary modifier submitted with the alternate procedure code for outpatient billing. We encourage you to purchase current copies of CPT, HCPCS and ICD code books.

The correct coding initiative edits and medically unlikely edits will apply to outpatient claims from the following hospitals and facilities:

- Acute care hospitals
- Long term acute care hospitals
- Ambulatory surgical centers
- Psychiatric facilities
- Substance abuse facilities
- Inpatient rehabilitation facilities
- Skilled nursing facilities

Note: Ambulatory surgical centers will follow institutional correct coding initiative edits for our commercial business, while our Medicare Advantage business will process against the professional edits.

Unlisted Procedure Codes

Unlisted procedure codes are not recommended for outpatient claims since they impact reimbursement of the claim. Refer to the outpatient payment programs section of this manual and the participation agreement for coding and reimbursement instructions.

Code Updates

The American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) update procedure codes to reflect changes in health care and medical practices. Coding updates occur quarterly with the largest volume effective January 1, of each year. Current Procedural Terminology (CPT) and Healthcare Common Procedure Code System (HCPCS) codes may be added, deleted, or revised with each update. International Classification of Diseases-9th Revision-Clinical Modification (ICD-10-CM) updates may occur bi-annually, with the largest volume effective October 1 of each year.

Modifiers

A modifier allows a provider to indicate that a service or procedure is altered by some specific circumstance, but the definition or code is not changed. Modifiers may be used in some instances when additional information is needed for proper payment of claims. Valid modifiers and their descriptions are found in the most current CPT and HCPCS coding books.

We process claims using only the first modifier for outpatient institutional claims. While up to three modifiers are accepted, claims are processed using only the first modifier. Therefore, submit the most important modifier affecting reimbursement in the first position on paper and electronic claims.

Note: If your claim is denied due to a lack of documentation to support the use of a specific modifier, you may submit an appeal. Your appeal must be submitted in writing and accompanied by the necessary documentation.

Modifiers may be used to indicate that:

- A service or procedure has been increased or reduced
- Only part of a service was performed
- A bilateral procedure was performed
- A service or procedure was provided more than once

Be sure to place any payment modifiers, especially those for National Correct Coding Initiative and Medically Unlikely Edits, in the first modifier position as Florida Blue has not yet enhanced our claim processing system to accept up to four modifiers.

If a claim did not process correctly because a payment modifier was placed in a modifier position other than the first position, please call the Provider Contact Center at (800) 727-2227 to let us know. We can change the modifier position and reprocess the claim.

Procedure Code Edits and Updates

Procedure Code Edits-Patient Billing Impact

The edits contained in the Claims Editing Tool are designed to provide appropriate coding, and to assist in processing claims accurately and consistently. The member is not responsible and should not be billed for any procedures for which payment has been denied or reduced as a result of column1/column2 and mutually exclusive edits.

Column1/Column2 and Mutually Exclusive Edits

Correct coding initiative (CCI) edits are pre-adjudication edits that prevent improper payment when incorrect code combinations are reported. Column1/ Column2 edits are code combinations that should not be reported together. Mutually exclusive procedures exist when a claim is submitted with two or more procedure codes that are not usually performed on the same patient, on the same date of service. These include combinations of procedures that may be anatomically impossible, represent overlapping and/or duplication of services, or are reported as both an initial and subsequent service.

One of the following denial reasons will be returned on the remittance advice depending on whether or not the code combination is allowed with or without a modifier:

- Mutually exclusive procedure
- Code 2 of a code pair not allowed
- Mutually exclusive procedure - Bill with appropriate mod.
- Secondary code not allowed - Bill with appropriate mod.

Medically Unlikely Edits (MUE)

A medically unlikely edit (MUE) for a HCPCS/CPT code is an edit applied to ensure accurate coding of units reported for outpatient claims. We use Medical Coverage Guidelines (MCGs) to define the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. This edit is not applied to all HCPCS/CPT codes. At this time, the maximum units for outpatient HCPCS/CPT code billing do not vary from those documented and used by Medicare. We use the existing MUE units for commercial and Medicare Advantage outpatient claims.

Note: If your claim denies due to the number of units reported for a service, you may submit a claim payment appeal. Your appeal must be submitted in writing and accompanied by the necessary documentation to support the number of services provided and for appropriate pricing of the claim.

The following denial reason will be returned on the remittance advice:

- EXCEEDS DAILY MAXIMUM LIMITATIONS

Periodic Updates

The claim editing tool is updated quarterly to accommodate coding changes. Refer to CMS website for the latest Claims Editing Tool updates. All claims submitted after the implementation date, regardless of service date, will be processed according to the updated version.

Tips

Diagnosis Codes: When reporting diagnosis codes, a decimal point must not be submitted as the decimal point is implied.

Single Date: Under 5010, a date range must be supplied, and a single date is no longer permitted

Admission Date: The admission date and hour only are allowed on inpatient claims and cannot be sent on outpatient claims.

Special Days: 5010 has deleted the 'Claim Quantity' segment which contained the total covered days, non-covered days, coinsurance days and the lifetime reserve days. These days will now be sent in the Value information segment. The four valid values are:

- 80 - Covered days
- 81 - Non-Covered days
- 82 - Coinsurance Days
- 83 - Lifetime Reserve Days

Service Facility Location Name: Required when the location of health care service is different than the billing provider. The Service Facility must be a non-person and must contain a valid 9-digit postal code or zip code.

Note: Additional Service Facility Location Billing and Claim information qualifying under the **No Surprises Act (NSA)** can be found here.

Outpatient Services "Priority Type of Admission or Visit" and "Point of Origin for Admission or Visit": Required for outpatient services submitted via paper or electronically for all bill types except 14X (Hospital laboratory Services provided to non-patients [OP/6]).

National Drug Code (NDC): Drug quantity information is now required when an NDC is submitted.

- As an NDC unit of measurement, milligrams (ME) has been added. However, Florida Blue does not recognize the ME unit of measure.

Inpatient Room and Board Rate Reporting

All Commercial and Medicare Advantage insurance products only cover semi-private room rates for an inpatient hospital stay. A private room is only covered if it is medically necessary or no semi-private rooms are available otherwise the difference between the private and semi-private room rate is a non-covered amount and patient liability.

Our Process

We send out a Facility Charge Form (FCF) with the annual inpatient DRG update that is for use by hospitals as a tool to report room rate charges. Based on the effective date of the updated FCF, we will update the hospital's files with the most prevalent (highest) semi-private room rate reported or if denoted as such a private room only indicator. If a hospital does not update this information annually, then the most recent rate historically reported by the hospital is contained in our claims system. If a hospital does not notify us of their room rate changes, accurate claim allowances cannot be determined.

BlueCard Process

Any inpatient private room differential will be determined based on the information submitted on the BlueCard claim. Our room rate information is only used when the hospital does not report a value code 01 or 02 as described below.

When a private room or deluxe private room is billed, recognized as revenue code 011X or 014X, and the hospital has both private and semi-private rooms available, then the hospital should report the semi-private room rate for the room type with value code 01. This rate will be used to determine the private room differential amount that is patient liability. If the hospital does not report the semi-private room rate, then the semi-private room rate from Florida Blue's provider files will be used to adjudicate the claim based on the rate's effective date and the admission date of the claim. If no semi-private rooms are available at the time of admission, then condition code 38 should be reported by the hospital on the inpatient claim.

If the hospital has only private rooms, then value code 02 and an amount of $0.00 should be reported on the claim. If not reported BlueCard claims will check for a private room only indicator on the Florida Blue provider file. If the hospital is designated as a private room only hospital, then value code 02 with an amount of $0.00 will automatically populate on the claim data sent to the member's Home Plan.

Professional Claims

Procedure Modifier and Diagnosis Codes

A critical element in claims filing is the submission of current and accurate codes to reflect the services provided. Correct coding is essential for correct reimbursement.

Inclusion of a complete and accurate list of diagnosis codes associated with the patient at the time of the encounter, including chronic conditions not necessarily treated at the time of the encounter, is part of correctly coding an encounter. It ensures that we can best match patients with appropriate care and disease management programs and members are properly classified by risk programs. We encourage you to purchase current copies of CPT, HCPCS, and ICD-10 CM code books.

Unlisted Procedure Codes

Report an unlisted code only if unable to find a procedure code that closely relates to or accurately describes the service performed. Whenever you submit an unlisted code, you must include a written description of

the services with the claim. Unlisted codes require documentation and therefore should not be submitted electronically; the exception is unclassified HCPCS drug codes (refer to Unclassified Drugs).

Code Updates

The AMA and CMS update procedure codes to reflect changes in health care and medical practices. Coding updates occur quarterly with the largest volume effective January 1 of each year. CPT and HCPCS codes may be added, deleted, or revised with each update.

ICD-10CM updates may occur biannually with the largest volume effective October 1 of each year.

Modifiers

A modifier provides a physician with the means to indicate that a service/procedure is altered by some specific circumstance, but not changed in its definition or code. By modifying the meaning of a service, modifiers may be used in some instances when additional information is needed for proper payment of claims. Valid modifiers and their descriptions can be found in the most current CPT and HCPCS coding books.

When multiple modifiers are necessary for a single claim line, modifiers should be submitted in the order that they affect payment.

Note: If your claim is denied due to a lack of documentation to support the use of a specific modifier, you may submit a claim payment appeal. Your appeal must be submitted in writing and accompanied by the necessary documentation.

Modifiers may be used to indicate that:

- A service or procedure has both a professional and technical component
- A service or procedure was performed by more than one physician and/or in more than one location
- A service or procedure has been increased or reduced
- Only part of a service was performed
- A bilateral procedure was performed
- A service or procedure was provided more than once
- Unusual events occurred

Crossover Claims

Medicare Crossover for Other Blue Plan Members (CMS-1500)

Completing a claim correctly when a member has primary coverage with Medicare and secondary coverage (Medicare Supplement) from another Blue Plan will decrease your chance of receiving claim denials. The following instructions apply to items on the CMS-1500 form or its electronic counterpart that require specific Medicare Supplement information:

Item 9

- Enter the last name, first name and middle initial of the member if it is different from that shown in Item 2. Otherwise, you may enter the word “SAME”. If no Medigap benefits are assigned, leave blank.

Item 9a

- Enter the Medicare Supplement member's policy and/or group number preceded by MEDIGAP, MG, or MGAP.
- Item 9d must be completed if you enter a policy and/or group number in 9a.

Item 9b

- Enter the birth date (MM/DD/YYYY) and gender of the member.

Item 9c

- Leave this field blank if the Blue Plan secondary payer's name is entered in 9d.
- Enter the correct Blue Plan name as the secondary carrier in 9c. For example, if the member has a Medicare Supplement with Blue Cross and Blue Shield (BCBS) of Michigan, then BCBS of Michigan should be indicated as the secondary carrier, not Blue Cross and Blue Shield of Florida (BCBSF). Use an abbreviated street address, two letter postal code, and zip code copied from the member's Medicare Supplement ID card. For example: 1234 Anywhere St, MD 12345.

Item 9d

- Enter the correct Blue Plan name as the secondary carrier.

Note: All information must be complete and accurate in items 9, 9a, 9b, 9c and 9d of the CMS-1500 form in order for the Medicare carrier to be able to forward claim information. If prior arrangements have been made with the private insurer, the carrier will forward the Medicare information electronically. Otherwise, the carrier will forward a hard copy of the claim to the private insurer.

Item 11d

- If you submit a claim with a Medicare Remittance Notice attached, always mark "YES" in 11d.
- If you mark "NO" in 11d, the claim will pass through the system, but attachments will not be reviewed.
- If your billing system is hard coded to mark "NO" automatically in 11d, please manually override your system to mark "YES" when submitting a claim with the Medicare Remittance Notice attached.

Item 13

- The signature in this item authorizes payment of mandated Medigap benefits to a participating physician or supplier if required Medicare Supplement information is included in items 9 through 9d.
- The member or member's representative must sign this item, or the signature must be on file as a separate Medigap authorization.
- The Medigap assignment on file in the participating physician or supplier's office must specify the insurer. It may state that the authorization applies to all occasions of service until it is revoked.

Medicare Crossover for Other Blue Plan Members (UB-04)

Completing a claim correctly when a member from another Blue Cross and/or Blue Shield Plan has primary coverage with Medicare will decrease your chance of receiving claim denials. The following instructions apply to items on the UB-04 form or its electronic counterpart that require specific Medicare Supplement information:

Form Locator 50 – Payer

- Enter "Medicare" as the primary payer on line A.
- Enter the appropriate Blue Plan name as the secondary payer on line B.
    - Not entering the member's actual Blue Plan as the correct secondary payer will result in claim issues. A claim crossed over in error to BCBSF cannot be processed and you may

not receive a remittance notice. Therefore, be sure to enter the correct Blue Plan when you submit the claim to Medicare. If your system is set-up to automatically populate BCBSF, please change it to the correct Blue Plan.

- If you do not know the member's Blue Plan, call BlueCard Eligibility at **(800) 676-BLUE (2583)**, speak the prefix and you will be routed to the member's Blue Plan.

Form Locator 53 – ASG BEN

- A "Y "indicating benefits were assigned must be entered in order for you to receive payment from the Blue Plan.
- This indicator authorizes payment of mandated Medigap benefits to you if required Medicare Supplement information is included on the claim.
- The member or representative's signature must be on file as a separate Medigap authorization.
- The Medigap assignment on file must specify the insurer. It may state that the authorization applies to all occasions of service until it is revoked.

Form Locator 54 – Prior Payments

- Enter the amount you have received toward payment of this bill from Medicare on line A.

Form Locator 58 – Insured's Name

- Enter the last name, first name and middle initial of the insured. The name must be entered exactly as it is on the ID card.

Form Locator 59 – P. Rel

- Enter the appropriate code indicating the relationship of the patient to the insured (e.g., code 18 = self).

Form Locator 60 – Insured's Unique ID

- Enter the patient's Medicare HIC number as shown on the ID card on line A.
- Enter the patient's complete Blue Plan ID number, including three-digit prefix on line B. Member IDs for other Blue plans include the prefix in the first three positions and can contain any combination of numbers and letters up to 17 characters.

Form Locator 61 – Group Name

- Enter the name of the group or plan through which the insurance is provided to the member.

Form Locator 62 – Insurance Group No.

- Enter the group number as identified on the ID card.

Filing the Medicare Cross-Over Claim

File the claim to your Medicare carrier for primary payment. Claim information will not be crossed over to the member's supplement plan (the secondary payer) until after Medicare has processed the claim and released it from the Medicare payment hold. Medicare secondary claims will normally be electronically forwarded by GHI (the CMS vendor) directly to the member's supplement Blue Plan for processing of the secondary benefits. Check the Medicare Remittance Notice to identify whether the claim was crossed over directly to the member's Medicare supplement Blue Plan. If it did, you do not need to take further action. The paper remittance notice will state "Claim information forwarded to: (Name of secondary payer). The 835 (electronic remittance) record can also carry the secondary forwarding information.

You will receive payment or processing information from the member's supplement plan after they receive the Medicare payment. Please allow 45 days from the Medicare payment date for the secondary claim (Medicare Supplement coverage) to process.

If the claim did not crossover electronically to the secondary payer (Medicare supplement plan), then file the claim to BCBSF with the Medicare Remittance Notice attached. Send the claim to:

Florida Blue
P.O. Box 1798
Jacksonville, Florida 32231-0014

Do not send secondary claims directly to the member's Blue Plan secondary payer.

Note: If more than one claim appears on the Medicare Remittance Notice, please indicate the specific claim you are filing.

Inquiries around Medicare Crossover Claims

Direct inquiries on secondary claims to Florida Blue unless the member's Blue Plan have requested specific information from you on a particular claim. Inquiries received on secondary claims by BCBSF will be coordinated with the member's Blue Plan for resolution.

Example: A provider received the primary Medicare payment. The Medicare Remittance Notice stated, "Claims information was forwarded to: (Name of secondary payer)." It has been 45 days since Medicare's payment and no communication has been received from the member's supplement plan. This should be sent to Florida Blue as an inquiry so the member's Blue Plan can be contacted, and a resolution made on the status of the secondary claim. Florida Blue will communicate the resolution back to the provider.

Ambulatory Surgical Center

Outlined below are generally accepted billing guidelines. This listing is illustrative only and is not intended to be all-inclusive.

- Submit one bill to Florida Blue for all services provided on the day, or within 72 hours, unless otherwise specified in your contract, of a performed surgical procedure. This includes all charges for pre-operative testing.
- No interim or split bills.
- Include charges for pre-operative testing related to surgery on the same bill as the surgery, whether or not the testing was provided on the date of surgery. The span date should reflect the date of the testing through the date of the surgery. The From Date and Admission Date will be the same if pre-operative services were performed.
- Submit the date of service on each detail line.
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes must be reported on each detail line when the revenue code is one of the codes listed here.
- Appropriate modifier codes should be reported for accurate application of Correct Coding Initiative (CCI) edits.
- Bill physician/professional fees on a CMS-1500 form only.

You no longer need to include a 51-modifier for routine/screening colonoscopy claims if the service is performed at an ambulatory surgical center (ASC). This change ensures that routine/screening colonoscopy claims with one or more additional procedures will process according to multiple surgery guidelines.

We encourage ASCs to update their billing systems accordingly as Florida Blue no longer requires a modifier in order to apply appropriate reductions for secondary surgical procedures. ASCs should continue to place appropriate National Correct Coding Initiative and Medically Unlikely Edit modifiers in the *first* modifier position on the claim form.

ASC Payment Program

Florida Blue has two different types of payment programs for ASCs:

- ASC Fee Schedule Program
- Outpatient Fee Schedule Program

ASC Fee Schedule Program

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

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

The ASC Fee Schedule Program utilizes seventeen all-inclusive surgery categories to determine the allowed amount. All other services will deny as included in the surgery. Multiple surgery reductions are incorporated in the program. In addition, the institutional correct coding initiative edits and medically unlikely edits apply to ASC payment programs. Florida Blue will apply outpatient facility edits and not professional edits to ASCs. The base fee schedule is the same for all ASC providers and for all lines of business, but the fee schedule reimbursement is calculated using the negotiated fee schedule percentage that is specific to each line of business. There are no services defined to reimburse at a percent of charges and there is no capped payment under the program. Implantable devices utilized in the performance of the surgery are not payable to the ASC. They must be obtained through the Implantable Device Procurement Program vendor which is Implant Procurement Group (IPG).

Refer to the Ambulatory Surgical Center Fee Schedule to view the surgery groupings and base fee schedule amounts by procedure code. See below for prior versions of the base fee schedule.

ASC Fee Schedule Allowance Calculation Examples

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

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

Fee Schedule (FS) Surgery

The allowance is determined by:

Fee Schedule Allowance			X	Fee Schedule Percent	=	Allowance
24515	$591		X	100% (1.0)	=	$591

Multiple Fee Schedule Surgery

The allowance is determined by:

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

Fee Schedule Allowance			X	Fee Schedule Percent	=	Allowance
24515	$591		X	100% (1.0)	=	$591

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

23650	$312	X	50% (.50)	=	$156
12005	$419	X	50% (.50)	=	$209.50
Total Allowance	$956.50				

Outpatient Fee Schedule Program

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

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

The FROM DATE is used for all outpatient pricing calculations.

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

- Fee Schedule Percent
  - Refers to the outpatient fee schedule differential as defined in your Agreement.
- Non-Fee Schedule Percent
  - Refers to the outpatient non-fee schedule differential as defined in your Agreement.
- Fee Schedule Surgery
  - Outpatient fee schedule surgery services will be paid at the rate set forth in your Agreement.
    - Fee schedule amount x fee schedule percent
  - The rate includes payment for the complete course of treatment (e.g., holding room time, operating room time, anesthesia time, recovery room time, all drugs and supplies, laboratory studies, radiology studies, EKG, and other procedures performed.
- Non-Fee Schedule Surgery
  - Non-fee schedule surgery is allowed at the approved charges multiplied by the non-fee schedule percent.
  - Covered ancillary services are allowed at (whichever is applicable) the:
    - Fee schedule amount x fee schedule percent or
    - Approved charges x non-fee schedule percent.
- Multiple Surgery Procedures
  - If more than one fee schedule surgery is performed, the surgical procedure with the highest fee schedule amount will be allowed at 100 percent; each additional fee schedule surgical procedure will be allowed at 50 percent of the fee schedule amount.
  - If both non-fee schedule surgery and fee schedule surgery are performed, all surgical procedures will be reimbursed at approved charges multiplied by the non-fee schedule percent.
- Bilateral Surgery Billing
  - A surgery procedure code reported with a 50 modifier (i.e., bilateral procedure) is considered to be two procedures. Bilateral surgery may be reported either on a single line with a 50 modifier or on two separate lines without the 50 modifier.

Example with 50 Modifier

Revenue Code	CPT Code	Description	Charge
0360	19101 50	Biopsy of breast; open, incisional	$1,500
Total			$1,500

Amounts shown are for illustrative purposes only.

Example without 50 Modifier

Revenue Code	CPT Code	Description	Charge
0360	19101	Biopsy of breast; open, incisional	$750
0360	19101	Biopsy of breast; open, incisional	$750
Total			$1,500

Amounts shown are for illustrative purposes only.

- Non-Surgical Ancillary Services
  - Fee schedule, non-surgical (ancillary) services are reimbursed at the rate set forth in your Agreement.
    - Fee schedule amount x fee schedule percent
  - Non-fee schedule, non-surgical (ancillary) services are reimbursed at approved charges multiplied by the non-fee schedule percent.
  - Non-surgical claims include such services as:
    - laboratory
    - laboratory pathology
    - diagnostic and therapeutic radiology
    - nuclear medicine
    - CT Scans and MRIs
    - emergency room, clinic, treatment room
    - pulmonary function
    - audiology
    - cardiology medicine
    - EKG/ECG
    - EEG
    - medical gastrointestinal services
- Cap
  - Cap refers to maximum allowance as defined in your Agreement.
  - Cap payment applies to claims in which all procedures billed are reimbursed at approved charges multiplied by the non-fee schedule percent. The allowance is based on, whichever is less:
    - the cap amount, or
    - approved charges x non-fee schedule percent
  - Cap is applied at the claim level.
  - Cap applies to claims in which all procedures are paid at approved charges multiplied by the non-fee schedule percent.

    - Implants, prosthetics and orthotics are not subject to the cap.
- Implant
    - Implant percent refers to the outpatient implantable device differential as defined in your Agreement.
    - Facilities with an agreement to procure implanted devices through a procurement service should follow instructions listed under the Implantable Device Procurement Program and should not include charges for the implanted device when billing Florida Blue.
    - Prosthetics, orthotics, and select implantable devices are reimbursed in addition to covered surgical procedures. Reimbursement is as follows:
    - Implants
        - Reported with revenue code 0275 (Pacemaker) or 0278 (Other Implants)
        - Allowance is based on approved charges multiplied by the implant percent.
        - Implants are not subject to the cap.
    - Prosthetics and Orthotics
        - Reported with revenue code 0274 (Prosthetic/Orthotic Devices)
        - Allowance is based on approved charges multiplied by the non-fee schedule percent.
        - Prosthetics and orthotics are not subject to the cap.
- Examples of items not considered for separate payment:
    - cataract lenses

Revenue and HCPCS/CPT Codes

The following chart identifies revenue codes that require a specific CPT/HCPCS code in field 44 of the UB-04.

The type of CPT/ HCPCS codes identified in the right column can only be reported with the revenue code(s) listed in the left column.

For example: laboratory procedures must be reported with a laboratory revenue code (0300 - 0309); a surgery CPT code may only be reported with those revenue codes identified and should not be reported with any other revenue code, such as, an anesthesia revenue code (0370).

Revenue Code	Description	CPT/HCPCS Code
0300 - 0309	Laboratory – Clinical Diagnostic	Code for lab procedure performed
0310 - 0319	Laboratory - Pathology	Code for pathology procedure performed
0320 - 0329	Radiology - Diagnostic	Code for radiology procedure performed
0333	Radiology - Therapeutic	Code for therapeutic radiology procedure performed
0340 - 0349	Nuclear Medicine	Code for nuclear medicine procedure performed
0350 - 0359	CT Scan	Code for CT scan performed

Revenue Code	Description	CPT/HCPCS Code
0360 - 0369	Operating Room Services	Code for surgery procedure performed
0400 - 0409	Other Imaging Services	Code for imaging services, such as, mammography, ultrasound, PET, etc.
0450 - 0459	Emergency Room	Code for visit or surgery procedure performed
0460 - 0469	Pulmonary Function	Code for pulmonary function procedure performed
0471	Audiology	Code for audiology service performed
0480 - 0483	Cardiology	Code for cardiology service performed
0490 - 0499	Ambulatory Surgical Care	Code for surgery procedure performed
0500 - 0509	Outpatient Services	Code for visit or surgery procedure performed
0510 - 0519	Clinic	Code for visit or surgery procedure performed
0610 - 0619	Magnetic Resonance Technology (MRT)	Code for MRI procedure performed
0730 - 0739	EKG/ECG	Code for EKG/ECG procedure performed
0740 - 0749	EEG	Code for EEG procedure performed
0750 - 0759	Gastrointestinal Services	Code for gastrointestinal service performed
0760 - 0769	Treatment/Observation Room	Code for visit
0790 - 0799	Extra-Corporeal Shock Wave Therapy	Code for extra-corporeal shock wave therapy procedure performed
0920 – 0925	Other Diagnostic Services	Code for diagnostic service performed (**Note:** Codes 51736, 51741,51792, 51795, 51797, 54240, 54250, 59020, and 59025 may also be reported using revenue codes 0920 - 0925)

Outpatient Fee Schedule Allowance Calculation Examples

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

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

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

Fee schedule Surgery

Fee Schedule Allowance			Fee Schedule Percent		Allowance
24515	$591	X	100% (1.0)	=	$591

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

Multiple Fee Schedule Surgery

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

Fee Schedule Allowance			Fee Schedule Percent		Allowance
24515	$591	X	100% (1.0)	=	$591

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

23650	$312	X	50% (.50)	=	$156
12005	$419	X	50% (.50)	=	$209.50
Total Allowance	$956.50				

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

Fee Schedule Surgery with Fee Schedule Ancillaries

The allowance is determined by:

Fee Schedule Allowance			Fee Schedule Percent		Allowance
24515	$591	X	100% (1.0)	=	$591

Fee Schedule Ancillaries are included in the surgery allowance.

81000	--	X	Included in allowance
73060	--	X	Included in allowance
71020	--	X	Included in allowance
93005	--	X	Included in allowance
Total Allowance	$591		

Cap does not apply

Fee Schedule Surgery with Non-Fee Schedule (NFS) Ancillaries

The allowance is determined by:

Fee Schedule Allowance			X	Fee Schedule Percent	=	Allowance
46255	$479		X	100% (1.0)	=	$479

Ancillary services are included in the surgery allowance.

0370	--	X	Included in allowance
0320	--	X	Included in allowance

Total Allowance $479

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

Fee Schedule Surgery with Implant

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

The allowance is determined by:

Step 1	Fee Schedule Allowance		X	Fee Schedule Percent	=	Surgery Allowance
	26531	$935	X	100% (1.0)	=	$935
Step 2	Approved Charge		X	Implant Percent	=	Implant Allowance
	0278	$800	X	90% (.90)	=	$720
Step 3	Surgery Allowance		+	Implant Allowance	=	Total Allowance
		$935	+	$720	=	$1655

Cap does not apply when any procedure is paid by fee schedule.

Non-Fee Schedule Surgery

The allowance is determined by:
The lesser of:

Cap dollar maximum $1,000 or

Approved Charge		X	Non-Fee Schedule Percent	=	Allowance
$450		X	50% (.50)	=	$225

$1000 > $225

Cap does not apply, as the approved charges multiplied by the non-fee schedule percent is the lesser.

Non-Fee Schedule Surgery and Fee Schedule Surgery

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

The allowance is determined by:
The lesser of:

Cap dollar maximum $1,000 or

Approved Charge		X	Non-Fee Schedule Percent	=	Allowance
$2100		X	50% (.50)	=	$1050

$1000 < $1050

Cap applies as the cap dollar maximum is the lesser of.

Non-Fee Schedule Surgery with Implant

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

Step 1 Surgery Allowance
The lesser of:

Cap dollar maximum $1,000 or

Approved Charge	X	Non-Fee Schedule Percent	= Surgery Allowance
$2200	X	50% (.50)	= $1100

Cap applies $1,000 < $1,100

Step 2 Implant Allowance

Implant Charge	X Implant Percent	=	Implant Allowance
$3500	X 90% (.90)	=	$3150

Step 3 Total Allowance

Surgery Allowance	+ Implant Allowance	=	Total Allowance
$1000	+ $3150	=	$4150

Non-Fee Schedule Surgery with Fee Schedule and Non-Fee Schedule Ancillaries

The allowance is determined by:

Step 1

Approved Charges		X Non-Fee Schedule Percent		= Non-Fee Schedule Allowance
10061	$450	X	50% (.50)	= $225.00
0370	$125	X	50% (.50)	= $62.50

Allowance = $287.50

Step 2

Fee Schedule Allowance	X Fee Schedule Percent	=	Fee Schedule Allowance
85025	$20 X 100% (1.0)	=	$20

Step 3

Non-Fee Allowance	+ Fee Schedule Allowance	=	Total Allowance
$287.50	+ $20	=	$307.50

Cap does not apply when any procedure is paid by fee schedule.

Fee Schedule and Non-Fee Schedule Surgeries with Fee Schedule Ancillary

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

Step 1	Approved Charges		X Non-Fee Schedule Percent	=	Non-Fee Schedule Allowance
	46255	$700	X 50% (.50)	=	$350
	10061	$450	X 50% (.50)	=	$225
					$575
Step 2	Fee Schedule Allowance		X Fee Schedule Percent	=	Fee Schedule Allowance
	81000	$15	X 100% (1.0)		$15
	71020	$25	X 100% (1.0)		$25
					$40
Step 3	Non-Fee Allowance		+ Fee Schedule Allowance	=	Total Allowance
	$575		+ $40		$615

Cap does not apply when any procedure is paid by fee schedule.

Fee Schedule and Non-Fee Schedule Surgeries with Non-Fee Schedule Ancillary

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

Cap dollar maximum $1,000 or

Approved Charges	X	Non-Fee Schedule Percent	=	Allowance
$1500	X	50% (.50)	=	$750
$450	X	50% (.50)	=	$225
Total $1037.50				

Cap does not apply when any procedure is paid by fee schedule.

Implantable Device Procurement Program for ASCs

Florida Blue has an Implantable Device Procurement Program was implemented and rolled out in a phased approach to all ASC networks. The program provides for the implementation of a new statewide implant device provider, Implantable Provider Group, and includes changes in the ASC reimbursement model for implantable devices.
This program applies to all lines of business with the exception of Medicare Private Fee-for-Service and Medicare Supplement.

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

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

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

Process for Obtaining Implantable Devices from IPG

Complete an IPG New Account Form available at www.IPG.com. This is a one-time process, which allows loading into the IPG system.
For questions on completing the form, participating providers should contact IPG.

Pre-Surgery

The ASC or the physician's office fax's the completed Patient Information Form to IPG at (866) 295-4773. You may substitute an existing Patient Demographic Form for IPG's Patient Information Form providing your version contains the same information as required on the IPG form. If you choose this option, please have IPG review your format to confirm that it will work.
Forms are available at www.IPG.com, IPG confirms receipt via phone or email and begins benefit verification process.

Device Approval and Scheduling

IPG provides written notification of acceptance via fax or email and sends a fax or email to the ASC confirming approval of the procedure.

Representative Delivery

(Manufacturer Representative brings implantable device to ASC)
Scheduling and Ordering: ASC schedules procedure and calls Manufacturer Representative to deliver device. ASC notifies IPG of procedure.

Delivery: Contracted Manufacturer Representative delivers implantable device to ASC.

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

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

Purchase: IPG issues Purchase Order to Manufacturer.

Billing Guidelines for Specific Services

Ambulatory Infusion

Ambulatory infusion services include the administration of drug therapy by infusion or inhalation and related services, under the supervision of a licensed health care professional to ambulatory patients in a room or office at an organization's site, which has been designated as an ambulatory infusion suite. All ambulatory infusion service providers submit claims utilizing a CMS-1500 form.

Specific billing requirements by place service are:

Ambulatory Infusion Suite

- Place of service 11 for services rendered in an Ambulatory Infusion Suite AIS
- SS modifier to be billed with nursing service (99601 and/or 99602)
- Appropriate home infusion per diem HCPCS
- Appropriate HCPCS for medication administered/infused

Note: Self-administered medication; medications covered by a member's pharmacy benefit; durable medical equipment, medical supplies and/or disposable supplies are not separately reimbursable.

Pain Management Services

The following information is intended for pain management rendered in a hospital or in an ambulatory surgical center.

The anesthesiologist may provide pain management services for acute (post-operative) or chronic pain. Pain management services typically consist of the administration of an anesthetic or analgesic agent by regional injection, causing partial or complete loss of sensation without loss of consciousness.

Injections or blocks administered as a therapeutic agent in the treatment of a non-surgical condition should be reported under the appropriate injection or block procedure codes. Nerve blocks and epidural steroid injections are reimbursed at a non-time-based rate.

Procedure code 62324 and 62326 should be reported for the insertion of a catheter for continuous epidural or subarachnoid drug administration. Reimbursement will only be made for covered services related to

chronic, intractable pain because of injury, illness, or post-operative pain management and any such payment will be presumed to include the following services:

- Initial placement of the catheter or cannula
- Monitoring of vital signs
- Subsequent injections
- Removal of catheter or cannula

The initial continuous epidural catheter placement procedure (62324, 62326) is reimbursed one time only at the beginning of the treatment program at a non-time-based rate.

Daily hospital management of epidural or subarachnoid continuous drug administration (01996) may be a covered service under appropriate circumstances. Reimbursement for daily hospital management performed on the same day as the initial continuous epidural (62324, 62326) is included in the basic allowance for the initial continuous epidural. Daily hospital management (01996) is limited to one time daily on subsequent days. Time units are not recognized for CPT code 01996. It will be paid the base unit of three times the conversion factor. If a physician is billing for more than one day on a claim, each day should be listed on a separate line to allow appropriate reimbursement.

Evaluation and management services relating to pain management services are covered according to Florida Blue Medical Coverage Guidelines.

Patient Controlled Analgesia

Patient Controlled Analgesia (PCA) therapy is a technique for pain management that involves self-administration of intravenous drugs through an infusion device. If PCA is initiated in the recovery room by an anesthesiologist as part of the anesthesia time, the initial set-up time for PCA may be incorporated into the total number of anesthesia time units reported.

To bill a PCA service after the anesthesia care has ended, the following items are needed; initial set-up, subsequent adjustments, or follow-up related to this therapy is considered routine postoperative pain management. Regardless of who performs the PCA, it is not separately payable. Additionally, if PCA is administered for non-surgical pain management, it is considered to be an integral part of a doctor’s medical care and is not eligible for payment as a separate and distinct service.

Payment for physician management related to PCA is included in the global fee paid to the surgeon and will not be separately reimbursed when billed by an anesthesiologist during the global period.

Virtual Visit

Definition

A Virtual Visit is an evaluation and management service or other service by a provider where patient care, treatment or services are rendered, in place of an in-person visit, through the use of real-time interactive telecommunications. Virtual Visits offer providers the option of delivering office/outpatient care services to our members via a virtual method when appropriate.

Reimbursement

Please refer to the site of service definition and review the payment policy on the Florida Blue site for further information regarding provider billing and reimbursement.

UB-04 Revenue Codes Requiring specific CPT/HCPCS

The following chart identifies revenue codes that require a specific CPT/HCPCS code in field 44 of the UB-04.

Revenue Code	Description	CPT/HCPCS Code
0300 - 0309	Laboratory – Clinical Diagnostic	Code for lab procedure performed
0310 - 0319	Laboratory - Pathology	Code for pathology procedure performed
0320 - 0329	Radiology - Diagnostic	Code for radiology procedure performed
0333	Radiology - Therapeutic	Code for therapeutic radiology procedure performed
0340 - 0349	Nuclear Medicine	Code for nuclear medicine procedure performed
0350 - 0359	CT Scan	Code for CT scan performed
0360 - 0369	Operating Room Services	Code for surgery procedure performed
0400 - 0409	Other Imaging Services	Code for imaging services, such as, mammography, ultrasound, PET, etc.
0450 - 0459	Emergency Room	Code for visit or surgery procedure performed
0460 - 0469	Pulmonary Function	Code for pulmonary function procedure performed
0480 - 0483	Cardiology	Code for cardiology service performed
0490 - 0499	Ambulatory Surgical Care	Code for surgery procedure performed
0500 - 0509	Outpatient Services	Code for visit or surgery procedure performed
0510 - 0519	Clinic	Code for visit or surgery procedure performed
Revenue Code	**Description**	*(continued on next page)*
0610 - 0619	Magnetic Resonance Technology (MRT)	Code for MRI procedure performed

0730 - 0739	EKG/ECG	Code for EKG/ECG procedure performed
0740 - 0749	EEG	Code for EEG procedure performed
0750 - 0759	Gastrointestinal Services	Code for gastrointestinal service performed
0760 - 0769	Treatment/Observation Room	Code for visit
0790 - 0799	Extra-Corporeal Shock Wave Therapy	Code for extra-corporeal shock wave therapy procedure performed
0920 – 0925	Other Diagnostic Services	Code for diagnostic service performed (**Note:** Codes 51736, 51741,51792, 51795, 51797, 54240, 54250, 59020, and 59025 may also be reported using revenue codes 0920 - 0925)

Billing Guidelines by Provider Type

Anesthesia Services

Services are provided by a qualified anesthesia provider to a surgical patient while in a state of analgesia or anesthesia so that surgical intervention can be undertaken. Anesthesia services consist of the administration of an anesthetic agent, typically by injection or inhalation, causing partial or complete loss of sensation, with or without loss of consciousness.

The anesthesia procedure is administered by a qualified anesthesia provider, which includes:

- Anesthesiologist (other than the operating physician, assistant surgeon, or obstetrician)
- Anesthesiologist Assistant AA
- Certified Registered Nurse Anesthetist (CRNA)
- Physicians qualified to administer general anesthesia or to appropriately supervise anesthesia professionals
- Usual preoperative and postoperative visits
- Anesthesia care during the procedure
- Administration of fluids or blood
- Usual monitoring (e.g., ECG, temperature, blood pressure, oximetry, capnography, mass spectrometry) as defined by American Society of Anesthesiologists (ASA) and/or CPT guidelines.

According to CPT guidelines, the reporting of anesthesia services is appropriate by or under the responsible supervision of an anesthesiologist. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure.

Non-Covered Services

Services not covered under the terms of the member's applicable Benefit Agreement include, but are not limited to, the following:

- Standby anesthesia – Florida Blue does not cover physicians "standing by" in anticipation of needing general anesthesia
- Anesthesia administered by operating physician or surgical resident
- Anesthesia by hypnosis
- Anesthesia by acupuncture
- Anesthesia for cosmetic surgery

Monitored Anesthesia Care

Intra-operative monitoring by an anesthesiologist, physician, or other qualified individual under the medical direction of the anesthesiologist, of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure.
Qualified anesthesia providers may bill Florida Blue directly for services using the anesthesiology codes 00100 – 01999. While some CPT surgical codes are appropriate to use when billing anesthesia services (e.g., 36620); the majority of anesthesia services should be billed using codes in the range of 00100 – 01999.

Qualifying Circumstances

Reimbursement for qualifying circumstances for anesthesia (99100-99140) is included in the basic allowance for other anesthesia procedures (00100-01999) when performed on the same day by the same physician. No additional reimbursement is allowed for CPT codes 99100-99140.

Moderate Sedation

Florida Blue separately allows moderate sedation provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, with procedures 99143-99145 except as follows:

- 99143-99145 will not be separately reimbursed with any procedures in Appendix G (refer to Summary of CPT Codes That Include Moderate (Conscious) Sedation) based on CPT guidelines.
- 99143-99145 will not be separately reimbursed with CPT and HCPCS procedures whose verbiage contains “with anesthesia,” “under anesthesia,” “under or requiring general anesthesia,” etc. based on their verbiage and the fact that moderate sedation is not expected with these procedures.
- 99143-99145 will not be separately reimbursed when billed with radiation therapy services, based on the National Correct Coding Initiative that contains edits bundling CPT codes 99143-99144 into all radiation therapy services.

Procedure codes 99148-99150 should be used if a second physician other than the healthcare professional performing the diagnostic or therapeutic services provides the moderate sedation.

Anesthesia for Multiple Surgeries

If you bill for the administration of anesthesia for multiple surgical procedures performed during the same operative session, submit only one anesthesia code. Choose the anesthesia code that best describes the procedure with the highest base value. Report the total time units to cover the additional time required for these procedures.

Anesthesia Modifiers

Modifiers are two-digit indicators that are used with a procedure code to add specific meaning to a service provided. Every anesthesia administrative code billed to Florida Blue must include a modifier. More than one modifier can be submitted per detail line; however, the Florida Blue claims system will adjudicate the claim based only on the first modifier submitted.

When an anesthesiologist medically directs the services of a CRNA or AA, it is recommended that **two separate claims** should be submitted using the same CPT code and the same amount of time on each claim with the appropriate modifiers.

In unusual circumstances, such as complicated trauma case, it may be necessary for both the CRNA and the anesthesiologist to be involved completely and fully in a single case. Both the CRNA and the anesthesiologist must submit documentation.

Primary Anesthesia Modifiers

Modifier	Description	Modifier Allowance Adjustment
AA	Anesthesia services performed personally by the anesthesiologist	100%
AD	Modifier AD (medical direction of five or more concurrent anesthesia procedures by an anesthesiologist) is not recognized by Florida Blue for reimbursement except for Medicare Advantage products.	0%
QK	Medical direction (by anesthesiologist) of two, three or four concurrent procedures by qualified personnel	50%
QY	Medical direction of one CRNA/AA by an anesthesiologist	50%
QX	CRNA/AA service with medical direction by an anesthesiologist	50%
QZ	CRNA service without medical direction by an anesthesiologist	100%

Secondary and Tertiary Anesthesia Modifiers

Modifier	Description
QS	MAC service. Only one QS service per day will be allowed.
23	Unusual Anesthesia. Occasionally a procedure that usually requires either no anesthesia or local anesthesia, because of unusual circumstances, must be done under general anesthesia. This circumstance may be reported by adding the modifier “23” to the procedure code of the basic service.
53	Discontinued Procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding the modifier “53” to the code reported for the discontinued procedure.
59	Distinct Procedural Service. Under certain circumstances procedures representing a different session or patient encounter, different site or organ system, separate lesions, or separate injury, not ordinarily encountered or performed on the same day by the same physician. Services with modifier 59 could be subject to Florida Blue review of medical records.

Billing for Medical Direction

When an anesthesiologist medically directs the services of a CRNA or AA, it is recommended that **two separate claims** should be submitted using the same CPT code and the same amount of time on each claim with the appropriate modifiers.

In unusual circumstances, such as complicated trauma case, it may be necessary for both the CRNA and the anesthesiologist to be involved completely and fully in a single case. Both the CRNA and the anesthesiologist must submit documentation.

Medical Supervision

When the anesthesiologist does not fulfill all of the "medical direction" requirements, the concurrent anesthesia services are considered medical supervision services and are not considered medical direction services. In this instance, the claim should be submitted as a CRNA service with the "QZ" modifier.

Physical Status Modifiers-Physical status modifiers distinguish between various levels of complexity of the anesthesia service provided based on the patient's condition and are represented by the letter P followed by a single digit**; Note:** Physical status modifiers do not impact reimbursement rates.

Modifier	Description
P1	Normal healthy patient
P2	Patient with mild systemic disease
P3	Patient with severe systemic disease
P4	Patient with severe systemic disease that is a constant threat to life
P5	Moribund patient who is not expected to survive without the operation
P6	Declared brain-dead patient whose organs are being removed for donor purposes

Regional Anesthesia

Topical anesthesia, local, local infiltration and/or metacarpal/digital block, is included in the basic allowance of the surgical procedure performed. No additional reimbursement is provided.

- Nerve Blocks -A nerve block involves the injection of a peripheral nerve into or around a given site. If the anesthesiologist administers the injection or block postoperatively in an area separate from the operating room as part of the anesthesia time, additional time required for the injection may be included in the total number of anesthesia minutes reported. If a qualified anesthesia provider remains with the patient, the time should be reported as continuous rather than discontinuous.
- Spinal, Subarachnoid or Subdural Anesthesia - Spinal, subarachnoid and subdural anesthesia involves the injection of anesthetic or narcotic drugs into the spinal cord. When performed as the primary type of anesthesia, the time required is included in the total anesthesia minutes reported.

- Epidurals -Epidural analgesia involves the administration of a narcotic drug through an epidural catheter. When performed as the primary type of anesthesia, the time required is included in the total anesthesia minutes reported.
- Labor Epidurals -Anesthesia for labor epidurals are time-based services and should be billed as total minutes.
    - 01967: Vaginal delivery with epidural for pain management. Code may be reported as a single anesthesia service. Depending on the terms of the participating provider agreement, reimbursement may be based on base units plus time units (insertion through delivery) subject to a cap of 7 hours or 420 minutes.
    - 01968: Cesarean delivery following failed attempt at vaginal delivery. This is an add-on code and should always be reported with 01967.
    - 01969: Cesarean delivery followed by a cesarean hysterectomy after failed planned vaginal delivery. This is an add-on code and should always be reported with 01967.

Note: Florida Blue has incorporated the NCCI Edits into our system. Transesophageal Echocardiography (TEE) Placement and Interpretation is no longer considered for separate reimbursement in addition to payment for the primary anesthesia procedure.

How to Calculate Anesthesia Reimbursement

Anesthesia Personally Performed by Anesthesiologist or CRNA (AA or QZ Modifier)
(Base Factor + Total Time Units) X Anesthesia Conversion Factor = Allowance

Anesthesia Performed under Medical Direction (QK, QX and QY modifiers)
[(Base Factor + Total Time Units) X Anesthesia Conversion Factor] X Modifier Adjustment .50 = Allowance for each provider

Behavioral Health Outpatient Clinic Groups

Behavioral Health Outpatient Clinic (BHOC) groups are comprised of outpatient clinics that provide professional services performed by Licensed Clinical Social Workers (LCSWs), Behavioral Analyst Doctorate (BCAD), Board Certified Behavioral Analyst (BCBA), Board Certified Assistant Behavioral Analyst (BCaBA), Licensed Marriage and Family Therapists (LMFT), Licensed Mental Health Counselor (LMHC), associated with Psychiatric and Substance Abuse (PSA) facilities and Community Mental Health Centers (CMHC).

BHOCs should be billing with place of service '11'.

The Facility's NPI number should be placed in block 24J and in block 33a. The individual rendering master level clinician NPI number is not needed for these claims.

IMPORTANT: LMHC and LMFT license types are excluded from seeing Medicare members.

Providers participating in the Lucet Behavioral Health network should follow billing guidelines as instructed by Lucet Behavioral Health via their website at https://lucethealth.com/ If there are any questions, Lucet Behavioral Health can be contacted by phone at **866-730-5006,** Fax: **904-371-6912.**

Behavioral Health Services

All types of behavioral health services are eligible for payment when provided under the direction of a physician in:

- Programs accredited by the Joint Commission for Health Care Organization (JCAHO), Commission on Accreditation of Rehabilitation Facilities CARF or in programs in compliance with equivalent standards.
- Alcohol rehabilitation programs accredited by the JCAHO, CARF or approved by the state of Florida.
- Licensed substance abuse rehabilitation programs (i.e., partial hospitalization program, intensive outpatient program).
- Member benefits and the severity of symptomology, rather than the diagnosis itself, determines whether or not a case will be eligible for payment of level of care requested. Cases are no considered eligible for payment if appropriate treatment can be provided in a less intensive setting of care.
- Eating disorders (anorexia, bulimia) are reviewed under the same criteria as other psychiatric disorders based on member benefits and the severity of symptoms.

Birthing Centers

If all of the member's obstetric care is performed through the birthing center, including antepartum and postpartum care, then the total care vaginal delivery (59400 SB) should be billed. In addition, RhoGam (J2790) and 76805 for one or more ultrasounds will be eligible for reimbursement.

If the member has been transferred from the birthing center prior to delivery, the CPT code reflecting such must be billed. If the member transfers to the birthing center prior to delivery, then the delivery only code or delivery with postpartum care code should be billed. If the member transfers to the birthing center after the birth, only the postpartum code should be billed.

Birthing centers are reimbursed with the following codes and/or modifiers.

- 59400 SB
- 59409 SB
- 59410 SB
- 59425 SB
- 59426 SB
- 59430 SB
- 76805
- J2790
- S4005 SB
- 99201-99205
- 99211-99215

No other global codes will be reimbursed.

Chiropractic Services

Chiropractic providers participating in the American Specialty Health (ASH) network should call 800-972-4226. All services are subject to medical necessity review.

Advanced imaging radiology (MRI/MRA, CT scan, CTA and PET) services should be referred to a participating Independent Diagnostic Testing Center. Refer to Florida Blue guidelines for more information.

For laboratory services authorized in an office setting, please see *In Office Laboratory List* located under the *Independent Clinical Laboratory* heading of the Standing Authorization section.

Diagnostic Imaging

If the treating chiropractic provider refers the reading or interpretation of a radiology service to a radiologist, reimbursement for the professional component of that service will only be made to the radiologist, and the treating chiropractic provider should not bill for that component.

Component Modifier Description of Services

- Professional 26 Services rendered by a licensed practitioner to perform the diagnostic interpretation of each study. It is required to document the diagnostic conclusions of the study by a written and signed radiology report.
- Technical TC Radiology services that include providing the facilities, equipment, resources, personnel, supplies and support needed to perform and produce the diagnostic study.
- Global N/A Combines both the technical and professional components in the service provided.

Laboratory

BlueCare, BlueMedicare HMO, BlueMedicare PPO, BlueOptions and SimplyBlue members covered in-office laboratory services are restricted to:
81000, 81001, 81002, 82947, 82948, 85014, 85025

All other laboratory services should be referred to Quest Diagnostics, Inc.

For BlueChoice and Traditional members, members may be referred to any Florida Blue contracted laboratories, including Quest Diagnostics.

Laboratory services for select health and musculoskeletal conditions may comprise one or more of the procedure codes on the list of in-office laboratory codes. Reimbursement for routine venipuncture for collection of specimen (36415) is only payable when paired with modifier 90 and when the laboratory sample is drawn in the chiropractor's office, but the sample is sent to an offsite laboratory for processing.

Please refer to the In-Office Lab List in the Standing Authorization section for the laboratory services eligible for payment when performed in the office.

Coding and Billing for Covered Services

The following Chiropractic Billing and Coding Guidelines should be read in conjunction with Florida Blue's Medical Policies (Medical Coverage Guidelines). Member benefits and procedure code edits always prevail.

Chiropractic physicians cannot subcontract to physical therapists, massage therapists, or acupuncturists in order to render chiropractic services to members and bill Florida Blue for those services underneath the chiropractic physician's scope of services. Should a qualified chiropractic provider refer a member to one of the ancillary providers listed, who is not an employee, and the qualified provider should follow normal referring provider practices.

All services must be performed in the office (POS 11) and includes:

Evaluation and Management

E/M codes are reimbursable only once per episode of care for the initial evaluation of a new or unrelated condition or injury. Re-examinations within an episode of care are reimbursable no more frequently than a monthly basis to assess patient progress, current clinical status, and to determine the need for any further medically necessary care. An episode of care is defined as evaluation, management, and treatment of a specific illness, injury, or condition related to an established date of onset and/or mechanism of injury, and comprising all services and procedures rendered during a planned course of care leading to resolution and/or stabilization of the condition with attainment of maximum clinical improvement by the member. Clinically indicated and medically necessary spinal and/or extra spinal manipulation on the same date of service may be reimbursed, subject to the member benefit agreement.

The chiropractic manipulative treatment codes include a pre-manipulation patient assessment. Additional E/M services may be reported separately using modifier 25, if the member's condition requires a significant separately identifiable E/M service, above and beyond the usual pre-service and post-service work associated with the procedure.

Chiropractic Manipulative Treatment

CMT is a form of manual treatment to influence joint and neurophysiological function. When similar or identical procedures are performed, but are qualified by an increased level of complexity:

- Only the definitive or most comprehensive service performed should be reported
- Only one CMT service of the spinal region (procedures 98940-98942) is eligible for payment on a single date of service.

Payment and Billing:

- Payment is limited to one clinically indicated and medically necessary physical medicine modality or procedure code per patient, per date of service.
- Payment is allowed for one clinically indicated and medically necessary extra spinal manipulation code (i.e., 98943-51) in combination with a spinal manipulation code (i.e., 98940, 98941, or 98942) per date of service.
- When multiple procedures are performed at the same session by the same provider, the modifier 51 may be appended to the additional CPT codes (excluding E/M codes).

Physical Medicine and Rehabilitation

The selection of appropriate physical medicine modalities and procedures should be based on the desired physiological response in correlation to the stages of healing. In most conditions or injuries, utilization of one carefully selected modality or procedure in combination with CMT is adequate to achieve a successful clinical outcome.

97140, manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes, will not be separately reimbursed when billed with 98940-98943 (CMT) for the same region. Modifier 59 should be used with 97140 when billed with a CMT code but performed on a different anatomical region.

It is not appropriate to bill 97124, massage, for myofascial release. For myofascial release, 97140 should be reported and is reimbursable if it is not billed with a CMT code pertaining to the same anatomical region. When reporting or billing for 97112 (neuromuscular reeducation) and 97124 (massage) as well as all other physical medicine modalities and therapeutic procedures, the details of the procedure shall be recorded in the medical record, including clinical rationale, anatomical site, description of service, and time (as required by the selected procedure code).

The "SZ" modifier should be used when providers are billing for Habilitative Services. This modifier is what differentiates habilitative services from rehabilitation services so that they accumulate to the habilitative services benefit maximum and not rehabilitation benefit maximum.

TENS: When found to be medically necessary, the following codes are reimbursed for TENS when billed under the following codes:

- E0720
- E0730

Acupuncture

A chiropractic provider may not provide acupuncture services until certified by the Florida Board of Chiropractic Medicine.

Acupuncture is reported based on 15-minute increments of personal (face-to-face) contact with the patient, not the duration of acupuncture needle(s) placement.

If no electrical stimulation is used during a 15-minute increment, use 97810 or 97811. If electrical stimulation of any needle is used during a 15-minute increment, use 97813 or 97814. Only one code may be reported for each 15-minute increment. Use either 97810 or 97813 for the initial 15-minute increment. Only one initial code is reported per day.

FEP requirement: Acupuncture must be performed and billed by a healthcare provider who is licensed or certified to perform acupuncture by the state where the services are provided

Covered Services for Medicare Advantage Members:

According to the Centers for Medicare & Medicaid Services (CMS) Internet-only manual, Publication 100-02 Medicare Benefit Policy Manual, chapter 15, section 30.5, chiropractors' services extend only to treatment by means of manual manipulation of the spine to correct a subluxation. All other services furnished or ordered by chiropractors are not covered.

Chiropractors are not limited to any specific procedures and may render services as they feel necessary, but according to CMS guidelines; the benefit will only cover manual spinal manipulation, which includes procedure codes: 98940, 98941, and 98942.

The following procedure code ranges will deny for chiropractors as non-covered services:

- 00100 through 98929
- 98943 through 99607
- A0021 through V5364

Chiropractic Modalities

- Physical Medicine and Rehabilitation
- CPT Code Description
- Supervised Modalities

The application of a modality that does not require direct (one-on-one) patient contact by the provider is as follows:

- 64550 Application of surface (transcutaneous) neuro stimulator
- 97012 Traction, mechanical
- 97014 Electrical stimulation (unattended)
- 97016 Vasopneumatic devices
- 97018 Paraffin bath
- 97022 Whirlpool
- 97024 Diathermy (e.g., microwave)
- 97028 Ultraviolet

Constant Attendance Modalities

The application of a modality that requires direct (one-on-one) patient contact by the provider is as follows:

- 97032 Electrical stimulation (manual)
- 97033 Iontophoresis
- 97034 Contrast baths
- 97035 Ultrasound
- 97036 Hubbard tank

Therapeutic Procedures

Physician or therapist required to have direct (one-on-one) patient contact. The therapeutic procedures, for one or more areas, each 15 minutes interval is as follows:

- 97110 Therapeutic exercises to develop strength and endurance, range of motion and flexibility
- 97112 Neuromuscular reeducation of movement, balance, coordination, kinesthetic senses, posture, and/or proprioception for sitting and/or standing activities
- 97113 Aquatic therapy with therapeutic exercises
- 97116 Gait training (includes stair climbing)
- 97124 Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
- 97140 Manual therapy techniques, one or more regions, each 15 minutes
- 97150 Therapeutic procedure(s), group (2 or more individuals)
- 97530 Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
- 97535 Self-care/home management training (e.g., ADL), each 15 minutes

Tests and Measurements (Requires direct on-on-one patient contact)

- 97750 Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
- Orthotic Management and Prosthetic Management
- 97760 Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes
- 97762 Checkout for orthotic/prosthetic use, established patient, each 15 minutes

Acupuncture

- 97810 Without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
- 97811 Without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)
- 97813 With electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
- 97814 With electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)

Florida Blue reserves the right to change the contents of the listing in accordance with revisions to industry standards, AMA/CPT guidelines, and with normal annual fee schedule coding updates.

Reimbursement

Florida Blue does not typically reimburse for the following chiropractic services:
Maintenance care: When the functional status of the member has remained stable for a given illness/condition/injury over approximately four weeks, without functional improvement in the member's net health outcome or expectation of additional objectively measurable clinical improvement.

Wellness or preventive care: Typically rendered on a regular or periodic basis to help maintain optimal body function, often when there is little or no activity-restricting symptomatology, or in order to support lifestyle activities such as high-performance sports.

Palliative or supportive care: Usually given after chronic symptoms have become stationary following completion of an initial course of therapeutic care; it may be used for repeated treatment of unresolved, recurrent, or chronic conditions including spinal subluxation or segmental dysfunction.

Convenient Care Centers (CCC)

Convenient Care Centers provide treatment for common illnesses, non-emergent or routine care. CCCs offer a narrow range of services that are offered in a PCP's office. An APRN, who is acting under the supervision of a physician/medical director, typically provides all services at a CCC. APRNs must be within the scope of their license according to the state of Florida and Florida Blue /Health Options criteria.

- Place of service "17"
- CCCs are reimbursed based on the following E/M CPT codes per the provider's agreement:
- 99202-99205
- 99211-99215

Note: Effective 01/01/2021 code 99201 is no longer an active code to bill for reimbursement. Covered services in convenient care centers do not include, well care visits, physicals, sutures, and treat broken bones or offer diagnostic studies such X-ray and laboratory. Any needed complex lab or radiology services will be referred to a participating lab, IDTC or PCP.

Dialysis Centers

Outlined below are generally accepted billing guidelines. This is intended to be illustrative and is not an all-inclusive list.

- Indicate “72X” type of bill. The third digit is based on the type of claim (interim, corrected, etc.).
- Hospital inpatient dialysis departments should bill with their hospital provider number and will be paid under the hospital agreement.
- Bill one claim per calendar month except when training is provided or when hemodialysis is performed in the same month as peritoneal dialysis.
- Do not submit claims that cross over from one month to the other. For example, service dates in January should be on one claim and service dates in February should be on another claim.
- Bill a line-item date of service for each revenue code billed on the claim form.
- Revenue codes should be listed in ascending numeric order by date of service and line item billed.
- Bill a separate line item for each dialysis session performed.
- Separately billable drugs, including EPO should be line item billed. Include the line-item date of service for the administration. Reimbursement will be calculated based on the units reported on the line.
- The units reported on the line for each date dialysis (codes 821, 831, 841 and 851) was performed should not exceed one.
- Height and weight should be reported for all ESRD patients.
- A8 – Weight in kilograms
- A9 – Height in centimeters
- Report modifiers, occurrence codes, and condition codes.
- Bill must include revenue codes and CPT codes for each line of service. For example, when billing hemodialysis submit revenue code 0821 with CPT code 90999.
- The training rate includes the composite rate. Therefore, the composite rate should not be billed separately for days when training was provided.
- Do not bill for hemodialysis and peritoneal dialysis composite rates on the same claim. In this situation, you must bill a claim for each type of dialysis provided within the same calendar month. Dates of service must not overlap.

Non-contracted Medicare Advantage

The following fields are required on all Medicare Advantage claims:

- A patient’s height and weight – entered in the value amount fields for value codes A8 and A9
- CBSA – must be included in the value amount field for value code 61

DME/HME Providers

For Durable Medical Equipment, Home Health or Home Infusion services, providers participating in the CareCentrix network should follow billing guidelines as instructed by CareCentrix. Contact CareCentrix via their website at CareCentrixPortal.com, or by phone at **877-561-9910** or Fax: **877-627-6688.**

Durable Medical Equipment/Home Medical Equipment (DME/HME) providers are expected to provide services only within the scope of their license. DME/HME is subject to review and reimbursement determination based on appropriateness, criteria, and the member's benefits. Therefore, in addition to the physician's order, supporting documentation may be required.

Items that do not require a physician's written order or prescription are generally non-reimbursable. Examples of non-reimbursable items include, but are not limited to, dispensing fees, sales tax (S9999), alcohol prep wipes and over the counter and disposable, one-time use items.

Note: Florida Blue applies Medical Policies (Medical Coverage Guidelines) to DME medical coverage requests.

General DME/HME-

- Date ranges are acceptable as long as they do not exceed a 31-day period in any billing cycle.
- All DME HCPCS codes must be submitted with the appropriate modifier (e.g., NU, RR or UE) that represents rental or purchase.
- Use specific and inclusive codes, when available, to prevent over utilization of miscellaneous codes (such as E1399) and inappropriate "unbundling."
- The member's benefits, medical coverage guidelines and your applicable Agreement(s) will determine the frequency to submit claims. Example: Continuous passive motion equipment (E0935) may be reimbursed daily for 14-days.

Medical Supply Companies

Medical supplies are items for health use, other than drugs, prosthetic or orthotic appliances, and/or durable medical equipment, that have been ordered by a qualified practitioner in the treatment of a specific medical condition and are consumable, non-reusable, disposable, for a specific (not incidental) purpose and generally have no salvageable value.
Medical supplies include, but are not limited to:

- Diabetic testing supplies (strips, lancets)
- Ostomy supplies
- Oxygen supplies
- Specialty dressings
- Urinary retention supplies

Billing Requirements

- Include a specific and inclusive codes, when available, to prevent over utilization of miscellaneous codes and inappropriate "unbundling."
- Medical supplies are not reusable and should be submitted with the NU modifier.
- Date ranges are acceptable, as long as they do not include dates of service in the future (e.g., diabetic testing supplies).

- For unlisted codes, include an itemized description with an invoice showing the MSRP for each unlisted code.

Non-Reimbursable Items

Items used in the course of professional treatment, given as take-home supplies or do not require a prescription are non-reimbursable.
Examples of non-reimbursable items include, but are not limited to:

- Dispensing fees (e.g., E0590, S9537).
- Implantable prosthetics (L8600-L8699), which are included in the facility or physician reimbursement.
- Sales tax (S9999) and
- Over the counter, disposable or one-time use items.

Respiratory Services

- Refer to the Medical Policies (Medical Coverage Guidelines) for specific coverage and documentation requirements,
- Oxygen equipment rentals include oxygen and are reimbursed as a monthly supply. Providers should bill each monthly supply as one unit (e.g., E0424, E0431, E0434, E0439, and E1390).
- CPAP/BiPAP must be billed with the appropriate modifier. Typical coverage of a positive airway pressure device is limited to a three-month trial period that requires billing with the rental modifier (RR) for the first three months.

Unlisted DME and Medical Supplies

- The use of miscellaneous/unlisted codes for billing DME is limited to the following:
- Circumstances for which there is no specific listed code available (e.g., equipment that cannot be grouped into other like items because it is new and unique in kind or form).
- Custom equipment: DME that is uniquely constructed or substantially modified to meet the specific needs of an individual patient according to the description and orders of a physician and is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes.
- Only those components of DME that are actually custom modified may be billed under unlisted codes. The claim should be itemized, not a grouping of all parts into one unlisted code.
- The following product documentation must be submitted with the claim for an unlisted code:
- Manufacturer’s itemized retail invoice
- Manufacturer’s name of the item or part
- Description of the item or part
- Manufacturer’s part number
- MSRP
- Completed CMN form for wheelchairs. Refer to the corresponding guideline in the online Medical Policies (Medical Coverage Guidelines) for a link to the CMN form.

General DME/HME Billing for:

Purchase

Used equipment is reimbursed at 75 percent of the purchase allowance,

Rental (short-term), Continuous or Perpetual Rental

Rental is only covered up to the purchase price. When the rental payments total up to the purchase allowance (usually at 10 months), a DME/HME item is considered purchased and no more payment is to be made. However, some DME/HME items are not purchased, but are rented perpetually, such as oxygen equipment and ventilators.

DME/HME rental fees will cover the cost of maintenance, repairs, replacements, adjustments, supplies, and accessories. Reimbursement will begin the day the device is delivered to the member.

Hearing Aid Dealers

Coverage depending on the terms and conditions of the member benefits. Hearing aid benefits exist for BlueCare, BlueChoice, BlueMedicare PPO, BlueOptions, SimplyBlue and Traditional members.

Routine hearing exams

- Conformity evaluations
- Hearing aids
- Hearing aid repairs
- Dispensing

Commonly billed codes include the following:

- Audiometric Tests
    - 92541-92568
- Auditory Functions
    - 92620-92621
- Conformity evaluations, hearings aids, hearing aid repairs, and dispensing fees
    - S0618
    - V5008-V5275

Home Health/Home Infusion Agencies

Florida Blue defines home health care services as those services rendered to an individual in the home by health care professionals (e.g., nurses, therapists) or paraprofessionals (e.g., home health aides, physical therapy assistants) to achieve and sustain an optimum state of health and independence for that individual. For purposes of coverage, home health care is provided on a per visit basis, generally for no more than two hours at a time.

Revenue Codes Used

- Home Health Aide
    - 0571
    - 0572 - hourly

CareCentrix Participating Providers:

For Home Health or Home Infusion services, providers participating in the CareCentrix network should follow billing guidelines as instructed by CareCentrix. Contact CareCentrix via their website at CareCentrixPortal.com, or by phone at **877-561-9910** or Fax: **877-627-6688.**

- If the agency does not bill on a calendar month basis, it prepares two bills. The first covers the period ending December 31 of the old year; the second, the period beginning January 1 of the New Year.
- All services must be itemized by date of service. Enter the appropriate revenue code and date for each service rendered.
- Physical therapy, speech therapy and occupational therapy services should be billed by the visit, not by the modality or hour, unless approved by Care Coordination.
- Reimbursement for visits provided by a health care professional of differing specialties is limited to one per day for each specialty, unless documented as medically necessary.
- Some plans, including BlueCard may require medical documentation for unlisted codes, such as 99600.
- Utilization of specific codes is strongly recommended to facilitate easier claims processing.

Florida Blue Medicare Billing Guideline for Home Health Prospective Payment System

Providers participating in the CareCentrix network: use link above to access billing and process information located in the *"Participating Provider Fee-For-Service Claims"* column of the matrix.

Home Health Billing Requirements for Non-Contracted Medicare Advantage

- Effective for home health episodes beginning on or after October 1, 2013, Original Medicare will no longer accept institutional claims submitted with Type of Bill 033X. After October 1, 2013, home health will need to bill with Type of Bill 032X.
- Bill type "322-329"
- Health Insurance Prospective Payment System (HIPPS) code
- Treatment Authorization Code
- Core-Based Statistical Area (CBSA) must be included with value amount field for a value code 61

Florida Blue Medicare Billing Guideline for Home Health Prospective Payment System

Non-participating Medicare Advantage providers: use link above to access billing and process information located in the *"Traditional Medicare and Non-Participant"* column of the matrix.

Billing for Infusion Services for Providers NOT participating in the CareCentrix Network:

Classified drugs must be submitted with valid CPT/HCPCS codes, HCPCS quantity, NDC Code, and NDC Quantity.

- Do not bill more than seven consecutive days on any claim line.
- Bill only primary drugs and S per diem codes related to infusion when professional nursing services are provided.
- Do not bill codes that are considered inclusive in the S per diem code.
- Corrected claims: if billing for additional dates of service or additional items, not included on the original claim, a corrected claim is required.
- Effective for home health episodes beginning on or after October 1, 2013, Original Medicare will no longer accept institutional claims submitted with Type of Bill 033X. After October 1, 2013, home health will need to bill with Type of Bill 032X.

- Home health providers with several provider numbers should submit the provider number of the agency that provided the care. This will ensure claims are reimbursed correctly.
- Submit both revenue and CPT/HCPCS Codes. Claims submitted without both revenue and CPT/HCPCS codes or with invalid codes will be rejected at the claim or line level.
- Bill according to CPT/HCPCS definitions to determine appropriate coding, inclusive supply and item sizing. Claim lines must be split unevenly when units exceed 9999 to prevent duplicate denials.
- Do not bill more than 15 lines or 31-days of services on the same claim. If billing for services over a span of dates, bill once for that span (after span is complete) to include all services for the dates of service on one claim. Overlapping or repeating span dates causes duplicate denials.
- The home health agency should not submit a bill/claim for an inclusive period beginning in one calendar year and extending into the next calendar year.
- A separate line item should be submitted for each per diem for each date of service. To report units per diem, one unit should be billed for each line.

Some groups and other Blue Plans may have specific coding and/or billing requirements for home infusion. Call the appropriate Blue Plan with any questions prior to filing the claim.

Billing Multiple Infusion Therapies

When billing home health services to Florida Blue, revenue codes and CPT/HCPCS should be reported using the most current publications. The matrix below indicates the commonly used the revenue codes to be used in billing home health/home infusion services.

- Multiple infusion therapies apply to patients who require multiple concurrent infusion treatments including, but not limited to, multiple antibiotics, hydration and chemotherapy.
- Reimbursement for multiple medications may be allowed with payment reductions, as noted per payment policy.
- The only exception to this is aerosolized AIDS drug therapy. It is the only therapy that must be billed in conjunction with another mode of home IV therapy administration. It is also the only drug therapy that, while provided as part of a multiple-therapy treatment, can be billed as a separate service.
- Use procedure code S9061 to report aerosolized AIDS drug therapy.

NOTE: Some groups and other Blue Plans may have specific coding and/or billing requirements for home infusion. Call the appropriate Blue Plan with any questions prior to filing the claim.

Revenue Codes Used

- General Classification Home IV Therapy
    - 0640
    - Non-routine nursing, central line 0641
    - Site Care, central line 0642
    - Start/Change, peripheral line 0643
    - Routine Nursing, peripheral line 0644
- Drugs
    - 0250-0252
    - 0630-0636

Independent Diagnostic Testing Center

IDTCs provide covered services to members as defined by Florida Blue in their applicable contractual agreement. Such services may include diagnostic radiology, diagnostic cardiology, neurology, and neuromuscular diagnostic.

Billing Requirements

- Contracted IDTCs are required to bill a global claim, which includes both professional and technical components.
- Claims submitted with either the professional or technical component will be denied for inappropriate billing.
- Procedure codes that specifically indicate contrast material is included in the service will not receive separate reimbursement for the contrast code.

Reimbursement

Reimbursement for covered diagnostic services is based on a global rate (professional and technical components combined). A physician may not separately bill the professional component of any procedure completed by the IDTC. The professional component is not eligible for separate reimbursement.

Orthotic and Prosthetic Providers

Orthotic services include the custom design, fabrication and fitting of braces and supports for the treatment of musculoskeletal conditions. These conditions may range from short-term sports related injuries to long-term progressive neurological diseases. Prosthetic services include the custom design, fabrication and fitting of artificial appliances used to replace or restore human body parts or organs in order to regain the loss functionality of the missing part.
Reimbursement for the following is included in the allowance for the covered orthotic or prosthetic device:

- Professional services for preparation and fitting
- Orthotic and prosthetic management (97760-97762)
- Hospital visits rendered in conjunction with an amputation procedure
- Cement, cleansers and other supplies used in "initial" implantation or insertion or application
- Travel time

Billing Requirements

- Specific and inclusive codes, when available, to prevent over utilization of miscellaneous codes (e.g., L2999) and inappropriate “unbundling.”
- Orthotics and Prosthetics are not reusable and should be submitted with the NU modifier.
- Repairs for Orthotics and Prosthetics should be billed using appropriate codes with documentation of what repairs were performed.
    - L4205 for repair of orthotic device, labor component; per 15 minutes
    - L7520 for repair of prosthetic device, labor component, per 15 minutes
- Repairs should not exceed the cost for a new device. If the expense for repairs exceeds the estimated expense of purchasing for the remaining period of medical need, no payment can be made for the amount in excess.
- Repair or replacement of a purchased item may occur when the item is irreparably damaged, or replacement is needed due to growth of a child or due to a change in the member’s condition.

- Replacement or repair of an item that has been misused or abused by the member or member's caregiver will be the responsibility of the member.
- For unlisted codes, include an itemized description with an invoice showing the MSRP for each unlisted code.

Non-reimbursable items include, but are not limited to

- Fitting or dispensing fees
- Sales tax (S9999)
- Items that do not require a physician's written order or prescription are generally non-reimbursable
- Implantable prosthetics (L8600-L8699), which are included in the facility or physician reimbursement

Note: Certain over the counter, non-durable items (e.g., arm slings, ace bandages, splints, foam cervical collars, etc.) are not eligible for payment because they do not fit within the definition of durable medical equipment, prosthetics or therapeutic orthotics.

Inpatient Hospital Requirements

Inpatient services are generally reimbursed based on one of the following:

- DRG, or
- Per Diem

Outlined below are generally accepted billing guidelines. This is intended to be illustrative and is not an all-inclusive list.

- The Admission Date field should reflect the true admission date for inpatient claims.
- The Statement Covers Period should reflect the beginning and ending service dates for the period included on the bill.
- The From Date should not be confused with the admission date.
- Day of Discharge or Death is not counted as a covered day, unless admitted and discharged/deceased on the same day.
- For institutional claims with Bill Type 11X, the number of Covered Days is required and must be reported using "Value Code" 80. Specifically, the number of Covered Days is a manual calculation of the length of stay by counting from the admit date to the day before discharge. Count all days except the day of discharge to get the patient's length of stay.
- Submit separate bills for mother and baby for obstetric and neonatal services.
- Reimbursement for newborn hearing screenings is included as part of the inpatient stay associated with a birth. It is the hospital's responsibility to establish payment arrangements with physicians for the technical portions of this service if the necessary equipment is not available at the hospital.
- Submit one bill to Florida Blue upon member discharge, transfer or death.
- All charges related to a hospital admission, including any charges for outpatient procedures, surgical or non-surgical (including observation), incurred within 72 hours of an admission (unless otherwise specified in your contract) must be itemized on the UB-04 bill for the admission and will be included in the inpatient allowance.
- All related services that lead to or are part of an admission, including transfers within the hospital (e.g., from a medical surgical unit to a psychiatric unit or acute rehabilitation unit), should be included on one bill when the hospital has not contracted with FloridaBlue for a Distinct Part Unit (DPU).

- Transfers within the hospital (e.g., from a medical surgical unit to a psychiatric unit or acute rehabilitation unit) are considered to be a continuous episode of hospital care and a single bill should be submitted unless the hospital has a separately licensed distinct part unit (DPU) and a separate contract for the DPU with BCBSF.
- All related services that are part of an admission should be included on one bill. Unless there are separate contracts for a hospital's DPU(s) and/or NPI's associated with any specialty unit or other hospital owned entity, the services should not be billed separately.
- When a hospital's DPU is contracted separately with defined reimbursement under the hospital agreement, those outpatient and inpatient medical services performed prior to the admission to the DPU are covered under the hospital's agreement. This includes any emergency room or observation services performed prior to an admission to the psychiatric DPU.

Exception: If separate contracts exist for a hospital's DPU(s) and/or NPIs associated with any specialty unit or other hospital owned entity.

- Include charges for preoperative testing related to surgery on the same bill as the surgery, whether or not the testing was provided on the date of surgery. For an inpatient claim, the From Date and Admission Date will be different, as the Admission Date will be the date the patient was admitted to the hospital while the From Date reflects the date pre-operative services were performed.
- No interim or split bills.
- Bill physician/professional fees (0960-0989) on a CMS-1500 form.
- For hospitals that have a per diem contract, the revenue code that applies to the specific per diem room and board rate or medical condition should be used (e.g., maternity/OB admissions should be billed with the applicable room and board revenue code ending with a 2).
- Florida Blue can only accept claims with up to 12 diagnosis codes and up to 6 procedure codes.
- Diagnosis codes impacting the DRG assignment should be in the first through 12 diagnosis code position.
- Report only the ICD diagnoses codes corresponding to conditions that affect the treatment received and/or length of stay.
- If surgery is performed and a charge is made for the operating room, recovery room, or special procedure room, an ICD procedure code must be entered on all inpatient claims.
- POA Indicators are required for all primary and secondary diagnosis codes billed on inpatient acute care hospital claims.
- A private room is only covered if it is medically necessary or no semi-private room is available. The difference between the private and semi-private room rate is a non-covered amount and the patient's liability. For information on billing and reporting inpatient room and board refer to Coding a Facility Claim.
- Care associated with HACs, as defined by CMS, is taken into consideration when the DRG is assigned. Those coded with an "N", or a "U" indicator will be excluded from the DRG grouping.
- Beginning **August 1, 2015,** for claim submissions where the member is admitted to the hospital through the emergency room, non-participating **BlueSelect** hospitals and facilities should submit two separate bills (one for emergency services and another for inpatient services) so that Florida Blue can apply the in-network benefits to the emergency room services.

Note: The "U" indicator is subject to specific guidelines with regard to the patient status code before it is excluded from the DRG grouping process.

Billing Scenarios:

Participating commercial hospitals with a distinct part unit (DPU) for behavioral health, skilled nursing and/or rehabilitation that is contracted separately under the hospital agreement for participation, would no longer submit a single bill for all services under the hospital's provider billing information. The medical services performed from an inpatient and/or outpatient setting would be subject to the hospital's reimbursement terms, while the DPU services would be subject to its reimbursement terms and two claims would be submitted.

If the contracted DPU only performs inpatient services, then the hospital can bill medical services (outpatient only or outpatient and inpatient) separately from the DPU inpatient services. This can happen if the member comes into the emergency room and is subsequently admitted to the DPU or if the member has an admission including inpatient medical and DPU days.

For outpatient medical services [ER, Observation (OBS), ER to OBS] leading to a behavioral health admission:

- The outpatient medical services should be submitted to Florida Blue under the hospital's NPI and taxonomy. This is required to ensure proper claims processing. First, it will ensure internally we map the correct Florida Blue provider id to the electronic claim and next it will ensure proper editing, so incorrect duplicate or other edits using same provider id, same member do not occur. The reimbursement for the outpatient claim will be subject to the hospital's outpatient reimbursement terms.

Note: Should obtain at least one authorization for behavioral health admission in this scenario. Two may be needed if the outpatient medical episode of care does not include emergency room (ER) depending on the member's product i.e., HOI/HMO.

For outpatient medical services leading to a medical admission and later a DPU admission (transfer) or a medical admission that also includes a DPU transfer admission:

- The outpatient and inpatient or inpatient only medical services should be submitted to Florida Blue under the hospital's NPI and taxonomy. These services are subject to standard hospital billing guidelines (i.e., related services) and the patient status should denote transfer if there was an inpatient medical admission as well. The claim is subject to the hospital's reimbursement terms.

- The inpatient DPU services should be submitted to FB under the DPU's NPI and taxonomy. This will ensure proper processing. The reimbursement for the DPU claim will be subject to the reimbursement terms defined for the DPU under their agreement with our vendor for behavioral health services.

NOTE: Should obtain at least one authorization for behavioral health admission but two may be necessary including one for medical admission depending on the member's product i.e., HOI/HMO or BlueSelect.

Outpatient medical then outpatient behavioral health services:

- DPU's typically perform inpatient services only as they represent specialized beds specific to the type of DPU. Unless the hospital's standard billing practice with Original Medicare is to bill outpatient behavioral health services under the DPU's provider information and not the hospital's, all outpatient services should be submitted on a single bill under the hospital's provider information. The entire claim would be subject to the hospital's reimbursement terms.

• If the designated DPU bills Original Medicare for outpatient behavioral health services, then the above guidelines for billing medical services under the hospital's provider info and behavioral health services under the DPU provider info applies. The outpatient behavioral health services allowed would be intensive outpatient or partial hospitalization. Any outpatient medical services would be billed under the hospital's NPI and taxonomy separately from any outpatient behavioral health DPU services.

Services Included in the DRG or Per Diem Payment

Examples of items that should not be submitted as separate charges since they are included in the DRG or per diem payment, as applicable:

- Non-physician professional services, including all non-physician professional personnel time.
- Supplies routinely provided with a service or procedure (e.g., X-ray film, lab collection devices).
- Re-stock charges, processing fees and other direct administrative expenses. Pharmacy compounding equipment, supplies and fees (e.g., Laminar flow hoods).
- Any indirect expenses, including but not limited to housekeeping, dietary, plant and equipment maintenance, utilities and insurance.

Partial Hospitalization

- Submit partial hospitalization services with the following revenue codes:
- 0912, 0913 or 0915
    - If a separate contract for the hospital and psych DPU are in effect, submit partial hospitalization services and inpatient services on separate UB-04 claim forms.
- Florida Blue considers partial hospitalization to be an outpatient service.
- Partial hospitalization for psychiatric or substance abuse admissions is calculated as follows:
    - Partial Days (including beginning and ending dates) x Per Diem.

DRG

DRGs are statistically meaningful medical groupings used for the purpose of categorization and reimbursement of hospital services.

- DRGs allow for more uniform billing based upon the member's diagnosis and procedures, age, sex, and discharge status.
- Reimbursement for DRG cases is based on discharge date.
- Exception: A newly established participating provider, under a DRG contract, will have the first year of claims reimbursed based on the admission date of the inpatient claim.
- Deaths and transfers are reimbursed based on the assigned DRG and payment hierarchy logic. There are no special reimbursement arrangements applicable to deaths and transfers.
- A list of DRGs, along with length of stay trim points and relative weights, is contained in your hospital's Agreement.

Outlier Cases

Outlier cases are exceptions to typical inpatient DRG cases. Refer to your Agreement for which outlier method applies.

There are three types of outlier cases but not limited to:

- Low length of stay outlier - Low Length is a case in which the member stays in the hospital fewer days than the low length of stay trim point.
- High length of stay outlier - High Length is a case in which the member stays in the hospital a greater number of days than the high length of stay trim point.
- High charge outlier- High charge is a case in which total covered charges exceed the high charge threshold.

DRG Hierarchy for a Standard Base Agreement

Each inpatient case for a DRG contract is evaluated using the following payment hierarchy:

- Low Stay Outlier
- High Charge/High Stay Outlier
- DRG Value Inlier

Once a claim meets the criteria for a step in the hierarchy table, then the reimbursement calculation method is based on that applicable step. For example, if a case meets the qualification as a low stay case and a high charge case, it will be reimbursed based on the low stay allowance.

Note: The hierarchy for a hospital that provides tertiary services is different from the hierarchy list above.

Calculating the Inpatient Allowed Amount

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

Determination of the allowed amount for inpatient and outpatient services is made based upon the terms of your Agreement.

DRG Examples

The following examples illustrate the various methods for determining the allowed amount for inpatient admissions.

Use the following “case” for the calculations:

- DRG = DRG 202 Bronchitis and Asthma, with complication or major complication
- Conversion Price = $3,000
- Low (Length of Stay) Trim Point = 2 days*
- High (Length of Stay) Trim Point = 12 days*
- Contracted Negotiated Low Stay Per Diem = $750
- Contracted Negotiated High Stay Per Diem = $800
- Relative Weight = 0.8446
- DRG Value = $2,534 (Conversion Price x Relative Weight)

*Trim point is a numerical value that represents the minimum (in the case of the low trim point) and the maximum (in the case of the high trim point) number of days for which payment will be made at the DRG value for hospital services. Length of Stay Examples

Per Diem

Per Diem is a per day negotiated rate which represents an allowance that includes all services for that day.

Per Diem agreements reimburse based on the admission date of the member.

The following terminology is used when referring to per diem contracts:

- Inliers- Inpatient cases reimbursed based on room and board per diem rates
- Outliers- Inpatient cases reimbursed as a DRG carve-out or based on catastrophic reimbursement.

Per Diem Hierarchy for a Standard Base Agreement

Each inpatient case in a per diem contract is evaluated using the following payment hierarchy:

- Implant Carve-out - Typically reimbursed in addition to inliers and outliers
- Catastrophic - Outlier
- DRG Carve-outs as case rate with additional day per diem - Outlier
- Per Diem Rates - Inlier

Once a claim meets the criteria for a step in the hierarchy table, then the reimbursement calculation method is based on that applicable step.

Calculating the Inpatient Allowed Amount

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

Determination of the allowed amount for inpatient and outpatient services is made based upon the terms of your Agreement.

Per Diem Examples

Per Diem payment rate is based on room and board revenue codes (e.g., med/surg, ICU, psychiatric) ranging from 110-219. The following examples illustrate the per diem methods for determining payment for inpatient admissions. Per Diem Examples

Present on Admission Indicator Reporting

A Present on Admission (POA) Indicator is used to identify whether a primary or secondary condition was present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered present on admission.

For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions known as, Hospital Acquired Conditions (HACs), are present at the time of admission. The case will be reimbursed as though the secondary diagnosis were not present. Critical Access Hospitals (CAHs), Long-term Care Hospitals (LTCHs), Cancer Hospitals, Children's Inpatient Facilities, Inpatient Psychiatric Hospitals, Inpatient Rehabilitation Facilities, and Veterans Administration/Department of Defense Hospitals are exempt from this payment provision.

The Florida Blue Present on Admission (POA) Indicator requirement applies to both Inpatient Prospective Payment Systems (IPPS) and Non-IPPS Hospitals. A POA indicator should be submitted with all primary and secondary diagnoses codes, regardless of whether the condition is considered a Hospital Acquired Condition (HAC) or not.

If an indicator of “Y” or “W” is submitted with a HAC condition, the major complicating condition or complicating condition (MCC/CC) is included in DRG grouping logic. HAC conditions submitted with an “N” or a “U” will be excluded from DRG grouping impacts. The “U” indicator is subject to specific guidelines with regard to the patient status code before it is excluded from the DRG grouping process.

NetworkBlue Providers

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

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

Option 1 - Lowest facility member cost sharing

Option 2 - Higher facility member cost sharing

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

For non-covered services, NetworkBlue providers may bill the member subject to any discounted rate which may be set forth in the NetworkBlue

Agreement or the amount agreed to by the member and the provider, whichever is less.

The table below outlines the payment implications for each of the different POA Indicator reporting options.

POA Indicator Options and Definitions

Code	Description
Y	Diagnosis was present at time of inpatient admission. Florida Blue will pay the CC/MCC DRG for those selected HACs that are coded as "Y" for the POA Indicator
N	Diagnosis was not present at time of inpatient admission. Florida Blue will not pay the CC/MCC DRG for those selected HACs that are coded as "N" for the POA Indicator.
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. Florida Blue will not pay the CC/MCC DRG for those selected HACs that are coded as "U" for the POA Indicator.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. Florida Blue will pay the CC/MCC DRG for those selected HACs that are coded as "W" for the POA Indicator.
1	Unreported/Not used. Exempt from POA reporting. This code was the equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A. For 5010 reporting, the 1 is no longer valid because POAs are no longer reported in a separate string. For a complete list of diagnosis codes on the POA exempt list, refer to ICD coding guidelines.

Outpatient Hospital Requirements

Outlined below are generally accepted billing guidelines.

Submit one bill to Florida Blue for: All services provided on the day or within 72 hours, unless otherwise specified in your contract, of a surgical procedure being performed. This includes all charges for pre-operative testing, or ER, ER to observation, or any outpatient services continuously provided that span multiple days.

- Span date billing for services other than surgery and related services within 72 hours (e.g., span dates for serial services, such as physical therapy and chemotherapy) should not be done unless specified differently in your contract because pricing may be applied incorrectly under a cap or threshold. If span date billing is allowed under your contract, then submit actual dates of service on different lines and submit a separate line for each different CPT or HCPCS procedure code reported
- No interim or split bills.

- Include charges for preoperative testing related to surgery on the same bill as the surgery, whether or not the testing was provided on the date of surgery. The span date should reflect the date of the

testing through the date of the surgery. The From Date and Admission Date will be the same if pre-operative services were performed.
- Submit the date of service on each detail line.
- CPT or HCPCS codes must be reported on each detail line when the revenue code is one of the codes listed here.
- Bill physician/professional fees (0960-0989) on a CMS-1500 form only.
- Florida Blue accepts and adjudicates claims with up to 12 diagnosis codes and up to 6 procedure codes.
- Appropriate modifier codes should be reported for accurate application of Correct Coding Initiative (CCI) edits.

Single Payment Category

The SPC is a hierarchical program that classifies each claim into a single payment category. All payment categories are classified based on identified revenue or CPT codes in a hierarchy. The hierarchy is the same for all providers and for all lines of business, but the rates for each payment category is separately negotiated.

There are 12 surgery categories in the hierarchy. The surgery categories are identified by revenue code or CPT code in the range of 10000 – 69999 and grouped together by APC relative weight or APC Status Indicator into the 12 surgery categories.

Single Payment Category SPC

- SPC's have separately negotiated all-inclusive flat payment rates, except for implants, prosthetics and orthotics.

Implants and prosthetics/orthotics

- Implants are defined as revenue codes 0274, 0275 and 0278, and should be reported with a CPT or HCPCS code.
- Implants are reimbursed above and beyond the percent of charge and flat rate allowances for all categories.

Lesser of charges or allowance functionality

This means that the total claim allowance, excluding implant allowances ("adjusted allowance"), cannot exceed the total claim covered charges, excluding the implant charges ("adjusted charge"). If the adjusted allowance exceeds the adjusted charge, then the new allowance is the adjusted charge. (*CPT code in the range 10000-69999 and not classified with an APC Status Indicator "N" or "X" **CPT code in the range 10000-69999 with an APC Status Indicator "C").

Physical Therapy Centers

Therapy centers may include licensed physical therapists, occupational therapists and speech-language pathologists. Therapy providers may only render those services within the scope of their license.

- Place of service '11'

Revenue Codes

- Occupational Therapy
  - 0434 – evaluation/re-evaluation
  - 0431 – visit charge
- Physical Therapy
  - 0424 - evaluation/re-evaluation
  - 0421 - visit charge
- Speech Therapy
  - 0444 - evaluation/re-evaluation
  - 0441 - visit charge

Appropriate therapy codes and specific DME codes as listed in negotiated fee schedule.

Physical Therapists/Occupational Therapists/ Speech-Language Pathologists

Physical and occupational therapy are provided for the purpose of restoring the functional needs of a patient suffering from physical impairment due to disease, trauma or prior therapeutic intervention.

Physical therapy (PT) is the treatment of disease or injury by the use of therapeutic exercise and other interventions that focus on improving or restoring posture, ambulation, strength, endurance, balance, coordination, joint mobility, flexibility, and ability to perform the functional activities of daily living and alleviating pain. Treatment comprises the use of the therapeutic proprieties of exercise, heat, cold, ultraviolet, electricity, and/or massage.

Occupational therapy (OT) is a prescribed program of treatment consisting of specific therapeutic and goal-directed activities to restore or improve skills needed to perform activities of daily living. Individual programs are designed to restore or improve the ability to conduct basic activities such as dressing, eating, personal hygiene and mobility/transfers. OT is generally focused on therapeutic activities intended to restore or improve function to the shoulder, elbow, wrist or hand.

Speech therapy (ST) is the treatment of communication impairment and swallowing disorders. Speech therapy services aid in the development and maintenance of human communication and swallowing through assessment, diagnosis and rehabilitation.

Autism Services - Licensed physical therapists, occupational therapists, speech-language pathologists and behavioral analysts may render autism services to applicable members in accordance with the Autism Mandate (Florida Statutes 627.6686 and 641.31098). Check eligibility and benefits to verify if a member is eligible. Refer to the Medical Policies (Medical Coverage Guidelines) for additional information.

Billing Requirements

Therapy providers may only render those services within the scope of their license.
Place of service '11'

Appropriate therapy codes, and specific DME codes as listed in the negotiated fee schedule.

Psychiatric and Substance Abuse Facilities

The information in this section pertains to members with PPO (BlueChoice, BlueMedicare PPO, and BlueOptions), Traditional and HMO (BlueMedicare HMO) coverage. All inpatient and outpatient behavioral health claims use the primary diagnosis code billed to determine the applicable per diem rate when a provider treats both types of behavioral health conditions. Florida Blue ensures services billed match the licensure provided at registration. If the scope of your license has changed, you should send updated information to Lucet Behavioral Health or for non-par facilities, to Florida Blue. Only the services listed on the license are set up under the provider's reimbursement rules. Any other services performed outside of the licensure provided, will be denied.

Note: All behavioral health services for Florida Blue members should be authorized through Lucet Behavioral Health.

- FEP Blue Focus members must obtain prior approval for services rendered by a Residential Treatment Facility.

Intensive Outpatient Program

Intensive outpatient program is defined as treatment that lasts a minimum of three hours a day for a minimum of three days per week in a structured program.

- Indicate "131" type of bill with revenue code 0905 for psychiatric services and 0906 for substance abuse services.
- For FEP members, IOP admissions must be certified.

Outpatient

Outpatient behavioral billing are for treatments that do not last longer than 80 minutes per day and are eligible for payment based on the terms of the rendering MD, PhD, or licensed masters level clinician's agreement. No more than one outpatient visit per day will be eligible for payment.

Note: Intensive outpatient programs and partial hospitalization programs are the only services eligible for outpatient facility billing. Any outpatient services that do not meet the requirements for IOP or PHP should be billed as professional services only.

Partial Hospitalization (PHP)

Partial hospitalization program is defined as treatment that lasts a minimum of twenty (20) hours per week, over a period of 3 days or more, in a structured program.

- Indicate "131" type of bill. (for all plans and products, participating and non-participating providers)
- For FEP members bill with the applicable revenue code 0912 or 0913. Do not bill revenue code 0169.
- Lucet Behavioral Health providers:
    - Revenue Codes 912, 913, 915. The primary diagnosis will determine the applicable per diem rate.
- Non-participating providers – bill with revenue codes 0912 and 0913.

Note: Revenue code 0915 for partial hospitalization services should not be billed if a provider's contract does not include this revenue code in their Lucet Behavioral Health agreement. These services will be denied as inappropriate billing if contractual reimbursement terms do not exist for this revenue code. Revenue code 914 - psychiatric/psychological services individual therapy or 915 - psychiatric/psychological services group therapy should be billed on a HCFA 1500 form as professional services with the appropriate professional HCPCS code. Claims will be denied as inappropriate billing when submitted on a UB04 or other institutional claim format.

Inpatient

Substance Abuse Services - Inpatient Revenue Codes

Service	Revenue Codes				
General Substance Abuse	118	128	138	148	158
Detox	116	126	136	146	156
Residential	1002				

Psychiatric Services - Inpatient Revenue Codes

Service	Revenue Codes					
Inpatient	114	124	134	144	154	204
Residential	1001					
Crisis Stabilization	204					

BlueCard

Providers should indicate “111” or “131” bill type; based on the member’s benefits.

Inpatient:

Indicate “111” bill type with room and board revenue code 0169

The days/units must be submitted on the line that contains revenue code 0169.
The applicable revenue code, 0912 or 0913, is reported on the following line.

Outpatient:

Indicate “131” type of bill with the applicable revenue code 0912 or 0913.
Do not bill revenue code 0169.

Note: For providers servicing BlueCard members: You must contact the home plan to determine if the member benefit for partial hospitalization as inpatient or outpatient; file your claim to Florida Blue accordingly.

Rehabilitation Facilities

Rehabilitation facilities are contracted to provide occupational, physical, and speech therapy.

- **OT** – Occupational therapists evaluate and treat problems interfering with functional performance. Targeted areas may include motor control/coordination, sensory motor skills, cognition, and visual perceptual skills.
- **PT** – Physical therapists evaluate and treat components of movement, which include range of motion, muscle strength, muscle tone, endurance, posture, balance and coordination, and mobility.
- **RT** – Respiratory therapists assess, evaluate, treat, manage, and care for patients with respiratory problems (e.g., asthma or emphysema). Clinical tasks are diagnostic and therapeutic to include administration of medical gases (i.e., oxygen, helium, and carbon dioxide), aerosol and humidity therapy, intermittent positive-pressure breathing therapy, incentive spirometry, artificial mechanical ventilation, arterial blood gas analysis, and pulmonary function testing. Respiratory therapists work under the supervision of physicians to administer prescribed respiratory therapy to patients with chronic illnesses. Outpatient services are only covered when provided in the comprehensive outpatient rehabilitation facility.
- **ST** – Speech-language pathologists evaluate and treat conditions relating to speech including: motor speech and voice disorders; expressive and receptive language disorders; articulation fluency; attention, memory, problem solving, and other cognitive deficits.

Note: Inpatient Rehabilitation Facilities are also contracted to provide medical and nursing services.

Inpatient Rehabilitation Facility Billing Requirements

- Indicate “11X” or “12X” type of bill
- First digit – type of facility (1-Hospital)
- Second digit – bill classification (1-Inpatient Hospital, including Medicare Part A or 2-Inpatient Hospital for Medicare Part B)
- Third digit – frequency (e.g., admit through discharge claim)
- Refer to contractual reimbursement terms to determine if billing is based on rehabilitation room and board revenue codes or HIPPS Case Mix Group codes. Typically, only Medicare Advantage contracts are negotiated based on the inpatient prospective payment system. (**Note**: HIPPS Case Mix Group code must be billed with revenue code 024).
- Room and board revenue code should be one of the following: 118, 128, 138, 148 or 158
- Submit actual number of days the member was in the facility. Day of discharge or death is not considered a covered day, unless admitted and discharged/deceased on the same day.
- Individual therapist providing occupational, physical and/or speech therapy may not bill separately for services provided in the facility.

Note: All charges for physician services should be billed separately on the CMS-1500 claim form.

To be eligible for admission to a Medicare-certified rehabilitation hospital or unit, members must require intensive rehabilitation services. The general threshold for establishing the need for inpatient hospital rehabilitation services is that the member must require and receive at least 3 hours of occupational and/or physical therapy per day. The therapy must be provided as treatment for one or more of the following conditions: amputation, brain injury, burns, congenital deformity, joint replacement, neurological disorders (including multiple sclerosis, motor neuron diseases, muscular dystrophy, polyneuropathy, and Parkinson's disease), osteoarthritis/hip, Polyarthritis (including rheumatoid arthritis), spinal cord injury, stroke, systemic vasculitis, and trauma (major or multiple).

Psychiatric and Substance Abuse Facility Transfer

The Psychiatric and Substance Abuse PSA facility must agree to transfer a member requiring acute care medical or surgical services, in a non-emergency situation, to the nearest participating provider that can furnish covered services.

- Do not bill the member for services that are deemed by Florida Blue as not medically necessary. The facility may bill the member for non-covered services per the member benefits.
- When two or more diagnoses are made for the same case, the primary diagnosis for billing purposes will be the diagnosis that precipitated the admission. The facility must bill the primary diagnosis as substance abuse unless a psychiatric condition is clearly the reason for admission, and can be substantiated by treatment plans, medical records, and psychological evaluations. Bill 23-hour observations as an inpatient service with a “111” type of bill, as well as separate admits and discharge dates.

Outpatient Rehabilitation Facilities Billing Requirements

- Multiple dates of service should not be grouped on one line.
- Indicate “74X” or “75X”’ type of bill, which is field 4 on paper claims
    - First digit – Type of facility (7)
    - Second digit – bill classification (4 for outpatient rehabilitation facility or 5 for comprehensive outpatient rehabilitation facility)
    - Third digit – frequency (e.g., admit thru discharge claim)
- The individual therapist providing occupational, physical, and/or speech therapy may not bill separately for services provided in the facility. The facility should bill these services using the appropriate CPT codes.

Skilled Nursing Facilities

Revenue Codes

- Skilled Nursing
    - 0551 – visit charge
    - 0552 - hourly
- Indicate “21X”, “22X” or “23X” in type of bill field, which is field 4 for paper claims.
    - First digit – Type of facility (2)
    - Second digit – Bill classification (inpatient - 1, inpatient Medicare B only - 2 or outpatient - 3)
    - Third digit – Frequency (e.g., admit thru discharge claim, etc.)
- Hospital Swing Bed claims should be billed with the “18X” type of bill and the taxonomy code for the hospital’s swing bed unit.
- For Florida Blue and BlueOptions members, provide the authorization/certification number on the claim. Plan of treatment should not be submitted with claim, unless requested.
- Submit room and board units to reflect the length of stay minus one unit for the discharge day. Day of discharge or death is not considered a covered day, unless admitted and discharged/deceased on the same day. For example, if a claim is submitted for dates of service 8/1/2014 to 8/7/2014, then the room and board units should be 6 to exclude the day of discharge or death.
- Refer to contractual reimbursement terms to determine if billing is based on Skilled Nursing Facility (SNF) revenue codes or HIPPS RUG codes. Typically, only Medicare Advantage provider contracts are negotiated based on the inpatient prospective payment system for SNFs.
- Florida Blue requires SNF claims are submitted with the 191-194 or 199 revenue codes that represent sub-acute care. Any inpatient SNF claims for non-BlueMedicare members that do not contain these specific room and board codes will be returned to the provider for appropriate billing.
- Florida Blue requires Long Term Care (LTC)/Custodial Care claims to be submitted with 101 Revenue Code.

Per Diem Levels for Skilled Nursing

Per Diem rates are based on the level of care assigned. Refer to applicable provider agreement for specific terms.

Inpatient Care

Type of bill (211-214)

Revenue code (0191-0194, 0199)

- Level 1 (Revenue Code 0191)
- Level 2 (Revenue Code 0192)
- Level 3 (Revenue Code 0193)
- Level 4 (Revenue Code 0194)
- Level 5 (Revenue Code 0199)
- All per diem rates will include, but may not be limited to the following services:
- Semi-private room
- Meals (including special dietary requirements)
- Skilled nursing care
- Case management
- Medication and pharmacy supplies
- Routine laboratory
- Routine radiology (except when excluded based on the terms of the agreement)
- Oxygen services
- Nutrition services (including enteral feedings)
- Administration of medications including intramuscular and intravenous services
- Medical supplies
- Discharge planning
- DME (excluding specialized/high cost DME*)
- Quality assessment and improvement programming
- Occupational, physical and speech therapy

All codes billed other than the per diem revenue codes (0191-0194, 0199) will be denied as included in the per diem rates. If the referenced per diem revenue codes are not submitted on the claim, the claim will be denied. Exceptions include outliers, instances where Blue Plan coverage is secondary to Medicare and other specific instances defined in the member's contract.

Participating SNFs can coordinate select medications with one of the pharmacy providers that are part of the SNF select medication program. These pharmacy providers will bill and be reimbursed directly for these services. Please refer to the Skilled Nursing Facility Select Medication Program details.

Any services not included in the per diem rate should be delivered and billed by participating providers outside the SNF. Contact Care Coordination for a list of participating providers for these services.

*Certain DME may be considered Custom DME due to its modification for use by a particular member. The term Custom DME shall mean equipment that is significantly altered or uniquely manufactured to meet the specific needs of an individual member according to the description and orders a physician or licensed practitioner whose license permits such practitioner to order Custom DME.

Outpatient Therapy Services for Skilled Nursing

Type of bill (231-234)

Outpatient therapy can be billed for occupational, physical and speech therapy rendered within the SNF.

- The individual therapist providing physical, occupational or speech therapies may not bill separately for services provided in the SNF.
- These services must not be billed during the same time frame as an inpatient claim.
- Outpatient services must be submitted on a separate claim from inpatient services.
- Outpatient therapy services should be billed with the following revenue codes:
    - 0420 for physical therapy
    - 0430 for occupational therapy
    - 0440 for speech therapy

Urgent Care Centers

Urgent Care Centers (UCCs0 are the delivery of ambulatory care in a facility dedicated to unscheduled, walk-in care outside a hospital emergency department.

Billing Requirements

- Place of service "11" or "20"
- UCCs are reimbursed based on the following E/M CPT codes per the provider's agreement:
    - Level 1
        - 99201
        - 99202
        - 99211
        - 99212
    - Level 2
        - 99203
        - 99213
    - Level 3
        - 99204
        - 99205
        - 99214
        - 99215
- UCCs should itemize all services rendered to the member, including the E/M code.
- To ensure appropriate reimbursement when rendering additional services (i.e., sutures, basic diagnostics, imaging, and laboratory tests), the modifier 25 should be applied to the appropriate E/M code.

Well-Child Care

Well-child care refers to physician-provided preventive health care services for children. The well-child benefit applies to an insured dependent child under BlueOptions, BlueChoice or Traditional products.

Well-child services include:

- The first newborn examination in the hospital by a physician other than the delivering obstetrician or anesthesiologist
- Periodic examinations to monitor the normal growth and development of a child
- Specified immunizations (see chart)
- Specified laboratory tests (see chart)

Well-child services are not subject to a calendar-year deductible and are reimbursed at the contracted percentage of the allowed amount.

Note: Florida Blue HMO (Health Options, Inc.) product, uses the USPSTF guidelines for preventive care and the recommended childhood immunization schedule published and updated annually by the Centers for Disease Control and Prevention.

The following chart outlines appropriate CPT codes to use when billing for well-child care services and the number allowed at each age interval.

Service	Procedure Codes	Age Category										
		0-1	1-2	3	4	5	6	7-8	9-10	11-12	13-14	15-16
Office Visit Hospital Visit	99381-99384, 99461, 99391-99394 99460, 99463	Preventive (well-child) visits are limited to 18 Periodic visits from birth through age 16										
Developmental Test	96110, 96111	1	1	1	1	1	1	1	1	1	1	1
Immunizations	90460-90474, 90633-90634, 90645-90649, 90655-90658, 90660, 90664, 90666-90669, 90680, 90696, 90698, 90700-90708, 90710, 90712-90713, 90714-90715, 90716, 90718-90721, 90723, 90732, 90733, 90734, 90740, 90743-90744, 90747-90748, G0008-G0010, J1670, S0195	BCBSF follows the recommended childhood immunization schedule published annually by the Centers for Disease Control and Prevention										

Service	Procedure Codes	Age Category										
		0-1	1-2	3	4	5	6	7-8	9-10	11-12	13-14	15-16
Preventive Medicine	99420, 99429	Services are eligible for coverage based on member contract benefits										
Preventive Counseling	99401-99404	3	3	3	3	3	3	6	6	6	6	6
	99411-99412	Services are eligible for coverage based on member contract benefits										

Service	Procedure Codes	Age Category										
		0-1	1-2	3	4	5	6	7-8	9-10	11-12	13-14	15-16
Lab Services												
TB	86580	1	1	1	1	1	1	2	2	2	2	2
UA	81000-81003	6	3	1	1	1	1	2	2	2	2	2
HCT	85004, 85007-85009, 85014, 85018, 85025	6	3	1	1	1	1	2	2	2	2	2
HBG	85027, 85032, 85041	6	3	1	1	1	1	2	2	2	2	2
UC	87086	6	3	1	1	1	1	2	2	2	2	2
Sickle - HB	83020	6	3	1	1	1	1	2	2	2	2	2
Sickle - SLD	85660	6	3	1	1	1	1	2	2	2	2	2
Lead	83655	6	3	1	1	1	1	2	2	2	2	2
PKU (In first month)	84030	2	0	0	0	0	0	0	0	0	0	0
Cholesterol	82465	0	1	1	1	1	1	2	2	2	2	2
Screening												
Ear	92551-92553	1	1	1	1	1	1	1	1	1	1	1
	92585-92588 (infant)	1	Additional services require medical review									
Eye	92002, 92004, 92012, 92014, 99172, 99173	1	1	1	1	1	1	Once every two years				

Billing Guidelines for Claims and Services Qualifying Under No Surprises Act (NSA)

Billing Procedures

Services rendered on or after January 1, 2022, by non-participating providers may be subject to requirements imposed by NSA rules.

Professional Claims – Service Facility Location

For physician and professional ancillary provider claims representing services performed in a hospital or facility setting, the Service Facility Location is a required field and must be populated. Florida Blue will be unable to properly identify physician and professional claims that qualify under the No Surprises Act if the Service Facility name and address is not provided. This applies to all hospital and facility based professional claims and all non-Medicare business, including BlueCard and FEP.

- It is preferred the hospital or ambulatory surgical center's NPI is also reported. The CMS 1500 claim form, field 32 (name & address), 32a (NPI number), 32b (qualifier/taxonomy code) should be submitted on the paper claim.
- Florida Blue requires the following information on the electronic professional claim format, 837P, SERVICE FACILITY LOCATION NAME in loop 2310C.
- Professional claims submitted for services performed in a hospital or facility settings must include the Service Facility information for correct processing. Claims will be denied if the Service Facility information is missing, incorrect or an individual, non-facility provider is reported.

Professional Claims from Independent Clinical Labs Qualifying Under NSA

Independent clinical lab provider claims that are performed on behalf of ambulatory surgical centers, must be reported with a place of service of 24 for Florida Blue to be able to identify those claims that qualify under the No Surprises Act. Independent clinical labs should already use the place of service where the specimen or blood was drawn, not the place of service where services were performed.

Institutional Claims versus Ground Ambulance

For Florida Blue to differentiate ground ambulance from air ambulance claims, air ambulance must be submitted with the proper revenue code (545 for air ambulance). The general revenue code for ambulance services, revenue code 540, has been linked to ground ambulance now that there is a dedicated revenue code to identify air ambulance. If air ambulance claims are not submitted with revenue code 545, the claim will not be identified as applicable to the No Surprises Act.

In addition, ground and air ambulance should not be submitted on the same claim. If billed on the same claim because they were performed by the same provider, the entire claim will be processed under the No Surprises Act including balance billing protection. To avoid this, ground and air ambulance services should be billed on separate claims.

Billing Guidelines for Drug Services

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

Outlined below are generally accepted billing guidelines. This list is intended to be illustrative and is not an all-inclusive list.

- All pharmaceuticals covered under the medical benefit must be approved by the FDA in order to be considered for coverage.
- All prescription drugs are to be billed using both the HCPCS and the NDC codes.
- Classified drugs are to be billed with the HCPCS, the HCPCS unit, and the NDC.
- Unclassified drugs are to be billed with the corresponding unclassified HCPCS, the NDC, and the NDC numeric decimal quantity based upon the assigned unit of measure (i.e., UN, ML, GR, etc.).
- If the HCPCS, the NDC, or the appropriate unit/ quantity are omitted, the claim will be rejected as incomplete and returned to the provider to correct the claim and supply the missing information.

Note: All claims submitted with a NDC Code must include the NDC in 11-digit numeric format, usually seen in a 5-4-2 format (e.g., 9999-9999-99). Occasionally NDCs are in 10-digit format and in such cases, providers must convert the 10-digit NDC to 11 digits.

- The NDC billing unit, quantity (metric decimal quantity), and unit of measurement are taken from the product label which aligns with the National Council for Prescription Drug Programs (NCPDP) standard billing units per NDC. NOTE – MG (ME) is not a unit of measure assigned to the NDC and/or recognized by NCPDP.

NDC Codes and Converting to 11-Digit Format

An NDC (National Drug Code) is a unique identifier which identifies a specific drug. Even though an NDC Code is assigned to a drug, the drug may not be approved by the FDA.

The NDC code(s) reported by the manufacture is the billable NDC code and is generally found on the drug container (i.e., vial, bottle, tube, etc.).
Note: In select instances, the manufacture reports the NDC code on the drug package which would be the billable NDC code based upon this being the NDC Code reported by the manufacture.

When coding a claim, the following NDC information is required to identify the drug services provided and prevent the services from being rejected:

- NDC Qualifier (N4)
- NDC Code (11 digits-see below)
- NDC Description (optional)

Refer to the below instructions for converting NDC codes into an 11-digit format (5-4-2) when the drug's NDC code is fewer than 11 digits:

Note: Any NDC code that is billed outside of the 11-digit format will be rejected.

Digit NDC format is	Then add a zero (0) in	Report NDC as
4-4-2 (9999-9999-99)	first position, **0**9999-9999-99	09999999999
5-3-2 (99999-999-99)	sixth position, 99999-**0**999-99	99999099999
5-4-1 (99999-9999-9)	tenth position, 99999-9999-**0**9	99999999909

NDC Quantity

NDC Quantity is based on the National Council for Prescription Drug Programs (NCPDP) standard billing units per NDC. The NDC Quantity identifies the drug dosage amount submitted for the NDC Code billed. In order to accurately report the NDC Quantity, the Unit of Measurement (UoM) assigned to the NDC Code must be applied and used to calculate the dosage amount. The dosage amount billed in the NDC Quantity must be billed with the actual metric decimal quantity (up to two decimal places) for the unit of measurement assigned to the NDC to prevent the services from being denied or underpaid.

Note: The NDC quantity must be rounded up to 0.01 in the metric quantity is less than 0.01 (i.e., 0.003, 0.0014, etc.)

There are four valid values (F2, ML, GR, UN) that can be used when reporting the unit of measurement. Each NDC Code is assigned a single UoM for the drug based upon how the drug is supplied.

Below is the unit of measurement descriptions and examples to assist with determining the unit of measurement (UoM) assigned to the NDC code to calculate the appropriate NDC quantity when billing claims.

- UN (Unit) - used when the products are dispensed in discreet units or vials that are powder form and have to be reconstituted before administration. These products are not measured by volume or weight. The NDC Code's reporting billing unit of "EA" applies to the "UN" unit of measurement.

Examples of drug products defined as "UN" Include but are not limited to:

Drug Name	NDC Code	NDC Billing Unit	Reported UoM
Adcetris 50 MG SOLR	51144-0050-01	UN	EA
Kyprolis 60 MG SOLR	76075-0101-01	UN	EA

- F2 (International Units) - used for measuring medications reported in International Units (e.g., antihemophilic factor)
- GR (Gram) - used to report a product measured by its weight. Commonly used in products supplied in ointment, cream, inhaler, or bulk powder in a jar. These are measured in as "GR" unit of measurement.

Examples of drug products defined as "GR" include but are not limited to:

Drug Name	NDC Code	NDC Billing Unit	Reported UoM
Morphine Sulfate POWD	00406-1521-53	GR	GM
Combivent Respimat 20-100MCG/ACT AERS	00597-0024-02	GR	GM

- ML (Milliliter) - used to report a product measured by its liquid volume.

Examples of drug products defined as "ML" include but are not limited to:

Drug Name	NDC Code	NDC Billing Unit	Reported UoM
Simponi 50MG/0.5ML SOLN	57894-0070-01	ML	ML
Zaltrap 100MG/4ML SOLN	00024-5840-01	ML	ML

When coding a claim for an unclassified drug, the following NDC Quantity values are required NDC Quantity

- Unit of Measurement (UN, F2, ML, or GR)

Providers must be able to enter and transmit the required NDC fields on professional claims (electronic or CMS-1500) submitted to Florida Blue and receive information about those fields on error messages and remittance advices (electronic and/or paper). This may require technical updates to your claim submission and billing systems.

Availity® includes the required NDC fields on its input screens. If your practice management system does not accommodate this requirement, contact your vendor to coordinate changes.

NDC to HCPCS Crosswalk

A critical component to filing claims with a NDC Code is to ensure that the appropriate HCPCS/CPT code is billed with the NDC Code. A NDC to HCPCS crosswalk identifies the assigned HCPCS/CPT code(s) for the NDC code associated to the drug service(s) billed based upon the information submitted and reported by the manufacture to ensure accurate appropriate billing of drug services, we use the crosswalk to determine whether the appropriate HCPCS/CPT code is billed for the submitted NDC code.

All drug services must bill the assigned HCPCS/CPT code(s) associated to the drug's NDC that was supplied/ administered based upon the drug form as supplied by the manufacture. In the instance a bulk powder is compounded, the NDC code applicable for the drug that was supplied by the manufacture as a bulk powder must be submitted; therefore, the HCPCS/CPT code billed must be applicable for the bulk powder and not associated to the form the drug was compounded into (i.e., pellet, injectable, tablet, etc.).

Below identifies multiple NDC to HCPCS Crosswalk examples:

HCPCS Drug Code	HCPCS Description	NDC Code	NDC Description (Brand Name)
J2270	Injection, morphine sulfate, up to 10mg	00548-3391-10	Morphine Sulfate 1MG/ML SOLN
J3490	Unclassified drugs	51927-1000-00	Morphine Sulfate POWD
S0020	Injection, Bupivacaine Hydrochloride, 30 mL	54569-3260- 00	Marcaine 0.25% SOLN
J3490	Unclassified drugs	54569-3260-00	Marcaine 0.25% SOLN
J1030	Injection, Methylprednisolone Acetate, 40 mg	00009-0280-03	Depo-Medrol 40 MG/ML SUSP
J1040	Injection, Methylprednisolone Acetate, 80 mg	00009-3475-03	Depo-Medrol 80 MG/ML SUSP
J0897	Injection, Denosumab, 1 mg	55513-0710-01	Prolia 60 MG/ML SOLN
J0897	Injection, Denosumab, 1 mg	55513-0730-01	Xgeva 120 MG/1.7ML SOLN
J7316	Injection, Ocriplasmin, 0.125 mg	24856-0001-00	Jetrea 0.5MG/ 0.2ML SOLN
J3590	Unclassified biologics	24856-0001-00	Jetrea 0.5MG/ 0.2ML SOLN
J9999	Not otherwise classified, antineoplastic drugs	00085-1388-01	Sylatron 296 MCG KIT
J3490	Unclassified drugs	37803-0203-05	Baclofen POWD
J7316	Injection, Ocriplasmin, 0.125 mg	24856-0001-00	Jetrea 0.5MG/ 0.2ML SOLN
J3590	Unclassified biologics	24856-0001-00	Jetrea 0.5MG/ 0.2ML SOLN
J9999	Not otherwise classified, antineoplastic drugs	00085-1388-01	Sylatron 296 MCG KIT
J3490	Unclassified drugs	37803-0203-05	Baclofen POWD

Note: Submitting a claim with a HCPCS/CPT code that does not align with the billed NDC code may result in a denial of payment.

Provider Administered Drug Program (PADP) Guidelines

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

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

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

For physicians who supply and bill and participate in the PADP program a pre-service review is required prior to the administration of certain specified drugs in the following settings: office, home, outpatient hospital, ambulatory surgical center, public health clinic and rural health clinic. If pre-service review is not obtained for the applicable drug, payment for that service will be denied. Members cannot be held responsible for denied charges.

Magellan Rx Management

Specialty Medications

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

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

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

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

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

2. Provide the medication from your own supply

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

Note - Refer to Specialty Pharmacy Remote Provider Guidelines in Utilization Management section of the provider manual

Unclassified Drugs

An unclassified drug is defined as a drug that does not have a specific, designated HCPCS/CPT code. Unclassified HCPCS/CPT codes should only be used when a specific HCPCS/CPT code is not available for the drug being billed. Claims being submitted with an unspecified HCPCS/CPT code when there is a designated HCPCS/CPT code for that drug will result in a denial of payment.
The following guidelines are for providers who submit unclassified drug codes on the CMS-1500 claim form or its electronic equivalent:

Apply the appropriate unclassified drug HCPCS/CPT (e.g., J3490, J3590, J9999, etc.) that is aligned with the billed NDC Code. The following identifies the list of unclassified drug HCPCS/CPT codes:

- 90399 – Unlisted Immune Globulin
- 90749 – Unlisted Vaccine/Toxoid
- A9699 – Radiopharmaceutical, Therapeutic, Not Otherwise Classified
- D9630 – Other Drugs and/or Medicaments, by report
- J1599 – Injection, Immune Globulin, Intravenous, Nonlyophilized (e.g., liquid), Not Otherwise Specified, 500 mg
- J3490 – Unclassified Drugs
- J3590 – Unclassified Biologics
- J7199 – Hemophilia Clotting Factor, Not Otherwise Classified
- J7599 - Immunosuppressive Drug, Not Otherwise Classified

- J7699 – NOC Drugs, Inhalation Solution Administered Through DME
- J7799 - NOC Drugs, Other Than Inhalation Drugs, Administered Through DME
- J8498 – Antiemetic Drug, Rectal/Suppository, Not Otherwise Specified
- J8499 – Prescription Drug, Oral, Non-chemotherapeutic, NOS
- J8597 – Antiemetic Drug, Oral, Not Otherwise Specified
- J8999 – Prescription Drug, Oral, Chemotherapeutic, NOS
- J9999 - Not Otherwise Classified, Antineoplastic Drugs
- Q0181 - Unspecified oral dosage form, FDA-approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment, not to exceed a 48-hour dosage regimen
- Q2039 - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified)
- Q4082 - Drug or biological, not otherwise classified, Part B drug Competitive Acquisition Program (CAP)
- S5000 – Prescription Drug, Generic
- S5001 – Prescription Drug, Brand
- Q9977- Compounded Drug, Not Otherwise Classified

The following are examples:

Unclassified Drug HCPCS	Unclassified HCPCS Description	NDC Code	NDC Description
J9999	Not otherwise classified, antineoplastic drugs	00085-1388-01	Sylatron 296MCG KIT
J3490	Unclassified drugs	38779-1756-00	Fentanyl Citrate POWD
J3590	Unclassified biologics	66658-0234-28	Kineret 100MG/0.67ML SOLN
J8499	Prescription drug, oral, non-chemotherapeutic, Not otherwise Specified	51655-0113-25	Benadryl 25MG CAPS
J8999	Prescription drug, oral, chemotherapeutic, Not otherwise Specified	59572-0410-00	Revlimid 10MG Caps
J7599	Immunosuppressive drug, not otherwise classified	00004-0298-09	CellCept Intravenous 500 MG SOLR
J7699	NOC drugs, inhalation solution administered through DME.	00487-9301-33	Sodium Chloride 0.9% NEBU
A9699	Radiopharmaceutical, therapeutic, not otherwise classified	50419-0208-01	Xofigo 27 MCCI/ML SOLN

Drug Wastage Modifier

- 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.

Surgical Implanted Pain Medication Pumps (SIPMP) Compound Drug Billing Guidelines

The following billing guidelines must be followed when submitting claims for SIPMP compounded drug(s) refills in order to prevent the services from denying or being underpaid.

- All services related to the SIPMP refill, programming, drug(s), and compounding must be submitted on the same claim for each date of service in order to be services from being denied or prevent a delay in payment.
- Each compounded drug(s) used for the SIPMP refill must be submitted on a separate line of the claim with the 11-digit NDC Code assigned to each of the drug(s) used in the SIPMP refill.
- The accurate NDC quantity (with the amount converted based upon the NDC assigned unit of measure) must be submitted in the metric decimal quantity (up to 2 decimal spaces – i.e., 0.01)
- When the NDC quantity is converted and the metric decimal quantity is less than 2 decimal places, the NDC quantity must be rounded up to 0.01. (i.e., 0.007, 0.0012, 0.0004, etc.)
- All compounded powder NDC codes are assigned a GR (Gram) unit of measurement, so the NDC quantity submitted must be for quantity amount based upon GR (Gram) unit of measure rounded up to 2 decimal quantities.
- If applicable, Florida Blue will allow a single ‘compounding fee’ up to $70.00 when submitted and billed appropriately. The compounding fee is reimbursing for any fees and/or supplies charges by the compounding pharmacy.
- In order to be considered for payment of the compounding fee, the following instructions must be used when submitting the claim:
- A separate line must be billed using the following data elements:
    - HCPCS code = J3490
    - NDC code = 00000000070
    - NDC quantity = 1
    - HCPCS quantity = 1

The following is an example to provide guidance with submitting an electronic and paper claim:

- The following identifies the information that may be referenced on the invoice received from the compounding pharmacy identifying the drug and amounts used for the patient that came into the office 04/17/2014 to have their SIPMP programmed and refilled:

**Invoice Example #1

Quantity	Description	Rate	Amount
	Delivery 04/15/2014 – patent, name *20cc pump*		
2,000	Fentanyl 10mcg/ml (NDC 38779-1756-06)	0.42	$40.00
200	Hydromorphone 20mg/ml (NDC 38779-0731-05)	0.37	$74.00
300	Bupivacaine 15mg/ml (NDC 38779-0524-05)	0.06	$18.00
	Supplies		$10.00
	Compounding Fee		$25.00
			$167.00

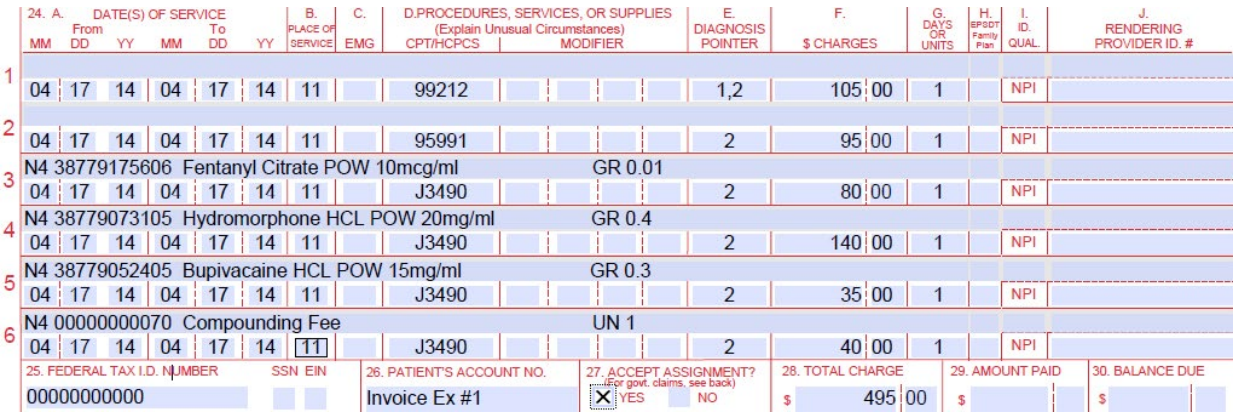
Based on the information noted in the example above: Please refer to the table on the following page to determine how the claims should be submitted for each service provided for the date of service

Claim Field Name	Claim Field Description & Guidelines	Electronic Claim Loop ID	Electronic Claim Segment	CMS-1500 Form Field
HCPCS/CPT Procedure Code	The appropriate HCPCS/CPT code(s) must be submitted for each service being billed on a separate claim line. For drug services billed, the HCPCS/CPT code aligned with the NDC must be submitted. Refer to NDC to HCPCS Crosswalk section of the Provider Manual NOTE – All SIPMP drug supplied by the manufacture in bulk powders must be billed with J3490	2400	SV101	24D
HCPCS/CPT Units	HCPCS/CPT quantity amount Enter the applicable units billed based upon the HCPCS/CPT code assigned dosage/quantity. (Unlisted Drug HCPCS/CPT codes do not have a specified quantity associated to the Unlisted HCPCS/CPT code. The HCPCS/CPT units billed should equal the number of drug containers (i.e., vial, bottle, tube) used for the services being billed.) NOTE - A HCPCS/CPT unit of 1 or greater must be billed on all claims	2400	SV104	24G
Monetary Amount	Enter the Total Charge Amount for each line of service	2400	SV102	24F

Claim Field Name	Claim Field Description & Guidelines	Electronic Claim Loop ID	Electronic Claim Segment	CMS-1500 Form Field
NDC Qualifier	Enter N4 in this field	2410	LIN02	
National Drug Code (NDC) and NDC Description	Enter the 11-digit NDC assigned to the drug administered/supplied (do not include hyphens/spaces). • 11-digit NDC Code is required using 5-4-2 format. Refer to Billing Guidelines for Drug Services for converting NDC to the 11-digit format.	2410	LIN03	24A (greyed field above From-To date)
NDC Quantity	The metric decimal quantity (rounded up to 2 decimal places) must be submitted on each SIPMP compounded drug-based Gram unit of measure. In the event the metric decimal amount is lower than 0.01, the NDC quantity must be rounded up to 0.01 (i.e., 0.004, 0.0021. 0.0006, etc.) In order to accurately report the NDC quantity, you must multiple the pump size by the drug quantity, then convert the quantity based upon Gram (GR). The following are the examples based upon the sample invoice above which identifies the pump size as 20cc: • Fentanyl 10mcg/ml (NDC 38779-1756-06) • 10mcg * 20cc = 200mcg • Convert quantity based Gram unit of measure = 0.0002 (since the quantity is less than 0.01, the NDC Quantity billed must be rounded up) 0.01 GR (grams – NDC quantity billed) • Hydromorphone 20mg/ml (NDC 38779-0731-05) • 20mg * 20cc = 400mg • Convert quantity based on Gram unit of measure = 0.4 GR (Grams - NDC quantity amount billed) • Bupivacaine 15mg/ml (NDC 38779-0524-05) • 15mg * 20cc = 300mg • Convert quantity based on Grams unit of measure = 0.3 GR (Grams – NDC quantity billed)	2410	CTP04	24D (greyed field above Modifier)

Claim Field Name	Claim Field Description & Guidelines	Electronic Claim Loop ID	Electronic Claim Segment	CMS-1500 Form Field
Unit of Measurement (UoM)	Each NDC quantity amount billed for the different SIPMP powders that are compounded must be billed based upon the GR (gram) unit of measure **NOTE – NDC Quantity should never be billed with a MG (ME) - milligram dosage being reported within the NDC quantity • MG is not a valid unit of measure for any NDC codes. Refer to the Billing Guidelines for Drug Services – NDC Quantity for assistance on identifying the appropriate unit of measurement assigned to the NDC Code.			

Below are examples of a paper claim submission identifying the detail lines billed for a single date of service based on the invoice samples; paper claim submission based on invoice Example #1 (referenced above)



	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04	17	14	04	17	14	11		99212		1,2	105 00	1		NPI	
2	04	17	14	04	17	14	11		95991		2	95 00	1		NPI	
3	N4 38779175606 Fentanyl Citrate POW 10mcg/ml									GR 0.01						
	04	17	14	04	17	14	11		J3490		2	80 00	1		NPI	
4	N4 38779073105 Hydromorphone HCL POW 20mg/ml									GR 0.4						
	04	17	14	04	17	14	11		J3490		2	140 00	1		NPI	
5	N4 38779052405 Bupivacaine HCL POW 15mg/ml									GR 0.3						
	04	17	14	04	17	14	11		J3490		2	35 00	1		NPI	
6	N4 00000000070 Compounding Fee									UN 1						
	04	17	14	04	17	14	11		J3490		2	40 00	1		NPI	

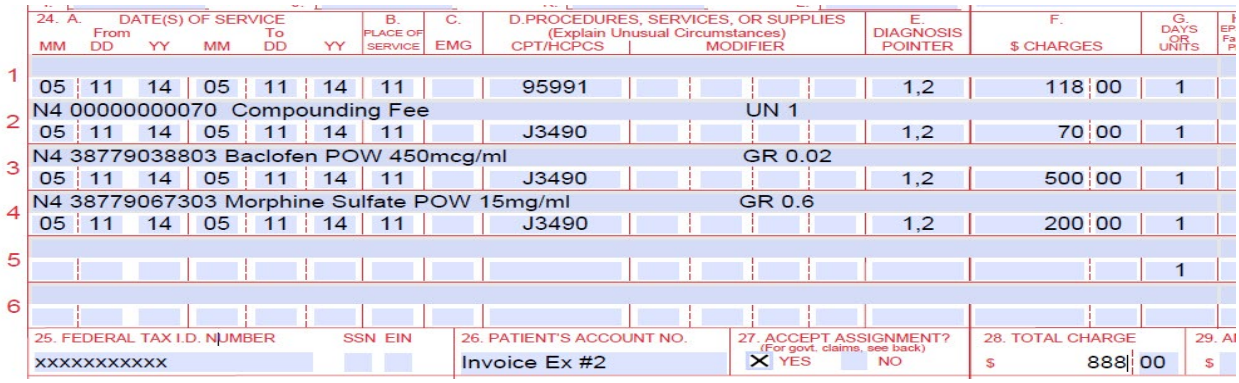
25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
00000000000			Invoice Ex #1	X YES NO	$ 495 00	$	$

Invoice Example #2

Order	Item Number	Description	Charge
1	H6B20	Morphine Sulfate (NDC 38779-0673-03) 15mg/ml / Baclofen (NDC: 38779-0388-03) 450 mcg/ml 40 cc pump Example#2, Patient	$610.00
	xxx	Compounding Fee	$55.00
		Total	$665.00

To determine the appropriate NDC Quantity:

- Multiply the dosage of each drug by the size of the pump
  - Morphine Sulfate (15mg X 40cc) = 600mg
  - Baclofen (450mcg X 40cc) = 18000mcg
- Convert the quantity into grams (g)
  - Morphine Sulfate 600 mg = 0.6g
  - Baclofen 18000mcg = 0.018g (round up to 2 decimal place 0.02 g)



	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
1	05 11 14 05 11 14	11		95991		1,2	118 00	1
2	N4 00000000070 Compounding Fee				UN 1			
	05 11 14 05 11 14	11		J3490		1,2	70 00	1
3	N4 38779038803 Baclofen POW 450mcg/ml				GR 0.02			
	05 11 14 05 11 14	11		J3490		1,2	500 00	1
4	N4 38779067303 Morphine Sulfate POW 15mg/ml				GR 0.6			
	05 11 14 05 11 14	11		J3490		1,2	200 00	1
5								1
6								

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. A
xxxxxxxxxxx	Invoice Ex #2	X YES NO	$ 888 00	$

Remote Specialty Pharmacy

Specialty Pharmacy providers are suppliers who dispense drugs and/or drug supplies that are covered under the medical benefit.

The physical locations of Specialty Pharmacies are located throughout the country; however, the orders submitted are requested by healthcare professionals that are located within various states and Blues Plan location of service.

In order for a Specialty Pharmacy provider to identify the appropriate 'local plan' for Blue Cross & Blue Shield (BCBS) members, the ordering provider and ordering provider's location must be identified. Whenever Specialty Pharmacy services are ordered by a healthcare professional or entity located within the State of Florida, the participation status of the Specialty Pharmacy Provider will be determined by its contract status with BCBSF/HOI. Similarly, when the ordering provider or entity is located outside of the State of Florida, the participation status of the Specialty Pharmacy Provider will be determined by its contract status with the Blue Cross and Blue Shield plan in the location.

- Example 1 - Remote Specialty Pharmacy Provider receives an order for a Florida Blue (BCBSF) member from a Provider located within the State of Arizona, the Specialty Pharmacy Provider's 'local plan' would be BCBS of Arizona.
    - The Specialty Pharmacy Provider's contracting arrangement with BCBS of Arizona would apply to determine if they are a participating or non-participating Specialty Pharmacy.
- Example 2 - A Florida Blue provider/entity submits an order to a Specialty Pharmacy Provider, the Specialty Pharmacy Provider's 'local plan' is Florida Blue.
    - If the Specialty Pharmacy Provider has a contracting arrangement with Florida Blue, the services would process as a participating provider (Caremark LLC is Florida Blue preferred Specialty Pharmacy Provider).
    - If the Specialty Pharmacy Provider does not have a contracting arrangement with Florida Blue (BCBSF), the services would be processed under the policies out of network benefits.

For all Specialty Pharmacies/ Pharmacies that will be billing Florida Blue (BCBSF) medical plan for the first time based upon the Ordering Provider being located within the State of Florida, please refer to the Provider Registration Form, in order for Florida Blue to obtain the appropriate operating documentation in order to:

- Submit and file claims electronically,
- Register with Availity®,
- Receive payment directly,
- Receive Electronic Payment Transactions (EFT),
- Prevent any delays in the processing of the claim(s), and
- Have the ability to utilize Florida Blue Provider Tools

Filing Professional Drug Claims

Electronic Claim Guidelines (ANSI 5010 837P) - Drug Field Values

Field Name	Field Description	Loop ID	Segment
HCPCS/CPT Procedure Code	Enter the appropriate HCPCS/CPT Code aligned with the NDC Code billed, if applicable.	2400	SV101
HCPCS/CPT Units	Enter the applicable units billed based upon the HCPCS/CPT code assigned dosage/quantity. The HCPCS/CPT unit must be submitted with a whole numeric value. (Unlisted Drug HCPCS/CPT codes do not have a specified quantity associated to the Unlisted HCPCS/CPT code. The HCPCS/CPT units billed should equal the number of drug containers (i.e., vial, bottle, tube) used for the services being billed.) **A HCPCS/CPT unit of 1 or greater must be billed on all claims**	2400	SV104
NDC Qualifier	Enter N4 in this field.	2410	L1N02
National Drug Code (NDC)	Enter the 11-digit NDC assigned to the drug administered/supplied (do not include hyphens/spaces). 11-digit NDC Code is required using 5-4-2 format.	2410	L1N03
Monetary Amount	Enter the Total Charge Amount for each line of service	2400	SV102
NDC Quantity	Enter the NDC quantity in decimal format (up to two decimal places) based upon the reported unit of measure assigned to the NDC Code. (NDC units billed must be converted based upon unit of measure assigned to NDC Code) **NOTE – NDC Quantity should never be billed with a MG (ME) - milligram dosage being reported within the NDC quantity • MG is not a valid unit of measure for any NDC codes. • Refer to Billing Guidelines for Drug Services – NDC Quantity for assistance on identifying the appropriate unit of measurement assigned to the NDC Code.	2410	CTP04

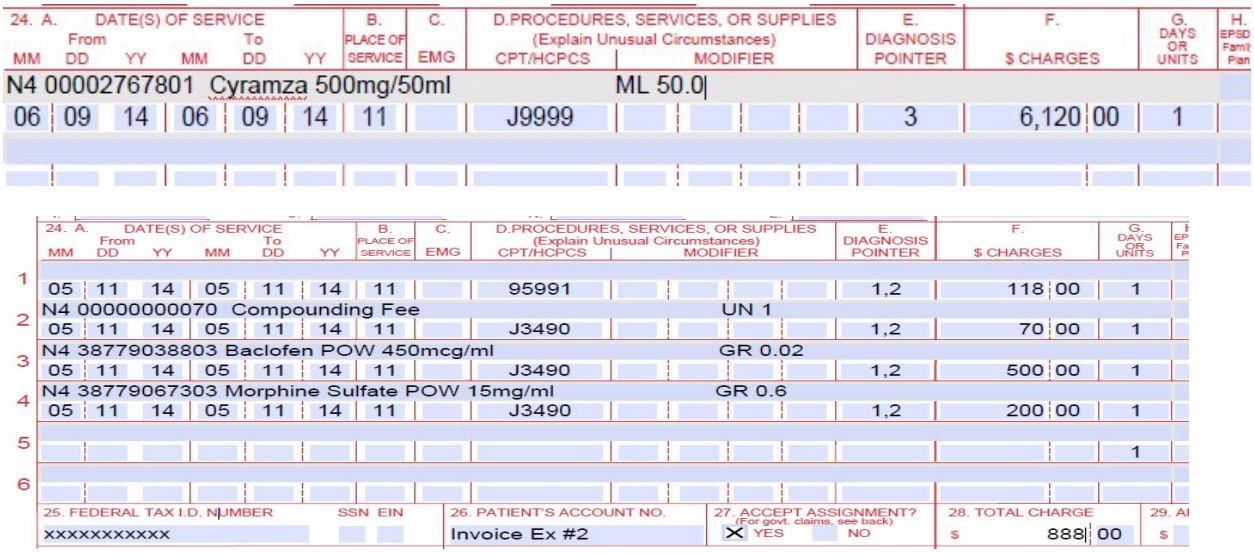
Field Name	Field Description	Loop ID	Segment
Unit of Measurement (UoM)	Enter the NDC unit of measurement associated to the billed NDC Code (UN, ML, or GR) • The NDC Quantity 4 units of measurement (UoM) reported for all drugs: UN, ML, GR, or F2. • There are no products currently reported with the unit of measure of F2 (international unit) • Refer to the Billing Guidelines for Drug Services – NDC Quantity for assistance on identifying the appropriate unit of measurement assigned to the NDC Code.	2410	CTP05

CMS-1500 Paper Claims

Field Name	Field Description	Field Location
HCPCS/CPT Procedure Code	Enter the appropriate HCPCS/CPT Code aligned with the NDC Code billed, if applicable. • Refer to NDC to HCPCS Crosswalk	24D (non-shaded field)
HCPCS/CPT Units	Enter the applicable units billed based upon the HCPCS/CPT code assigned dosage/quantity. The HCPCS/CPT unit must be submitted with a whole numeric value. (Unlisted Drug HCPCS/CPT codes do not have a specified quantity associated to the Unlisted HCPCS/CPT. **A HCPCS/CPT unit of 1 or greater must be billed on all claims**	24G
NDC Qualifier, National Drug Code (NDC) and NDC Description	Enter N4 in this field followed by the 11-digit NDC assigned to the drug administered/supplied (do not include hyphens/spaces) with the drug description proceeding the NDC code. • 11-digit NDC Code is required using 5-4-2 format. • Refer to Billing Guidelines for Drug Services – NDC Codes and Converting to 11-Digit Format to convert NDC to the 11-digit format.	24A (greyed field above From-To date)

Field Name	Field Description	Field Location
Monetary Amount	Enter the Total Charge Amount for each line of service	24F
NDC Quantity	Enter the NDC quantity in decimal format (up to two decimal places) based upon the reported unit of measure assigned to the NDC Code. (NDC units billed must be converted based upon unit of measure assigned to NDC Code) **NOTE – NDC Quantity should never be billed with a MG (ME) - milligram dosage being reported within the NDC quantity • MG is not a valid unit of measure for any NDC codes. • Refer to Billing Guidelines for drug services – NDC Quantity for assistance on identifying the appropriate unit of measurement assigned to the NDC Code.	24 D
Unit of Measurement (UoM)	Enter the NDC unit of measurement associated to the billed NDC Code (UN, ML, or GR) • The NDC Quantity 4 units of measurement (UoM) reported for all drugs: UN, ML, GR, or F2. • There are no products currently reported with the unit of measure of F2 (international unit) • Refer to the Billing Guidelines for Drug Services – NDC Quantity for assistance on identifying the appropriate unit of measurement assigned to the NDC Code.	24D (greyed field above Modifier before the NDC Quantity)

The following is the full screen shot of the above field images reported



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan
N4 00002767801 Cyramza 500mg/50ml									ML 50.0				
06	09	14	06	09	14	11		J9999		3	6,120 00	1	

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	EP Fa Pl
1	05	11	14	05	11	14	11		95991		1,2	118 00	1	
2	N4 00000000070 Compounding Fee									UN 1				
	05	11	14	05	11	14	11		J3490		1,2	70 00	1	
3	N4 38779038803 Baclofen POW 450mcg/ml									GR 0.02				
	05	11	14	05	11	14	11		J3490		1,2	500 00	1	
4	N4 38779067303 Morphine Sulfate POW 15mg/ml									GR 0.6				
	05	11	14	05	11	14	11		J3490		1,2	200 00	1	
5													1	
6														

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. A
xxxxxxxxxx			Invoice Ex #2	X YES NO	$ 888 00	$

(continued on next page)

Medical Pharmacy Services

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

Note: Please refer to member Home Health benefit information and the DME/HME Providers information found within this manual when pharmaceutical services are administered by a home health provider.

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

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

Reimbursement Exception Drug Pricing - Unclassified Drug Payment Policy

The term unclassified is used to describe a drug that does not have a specific designated code in the Healthcare Common Procedure Coding System (HCPCS) or the Current Procedural Terminology (CPT®) Manual. It is the responsibility of the user of the HCPCS or CPT® coding systems to verify the use of an unclassified drug code, and to verify that a valid listed code for the form of drug administered does not exist. The codes for unclassified drugs should be used as a last resort or when instructions specify their use.

Unclassified HCPCS codes can only be used when there is not a specific HCPCS code available for the drug NDC being billed. Submitting a claim with an unspecified HCPCS code when there is a specific HCPCS code for that drug will result in a denial of payment.

Each NDC associated with an unclassified drug code should be submitted on a separate claim line.

As determined by Florida Blue, an exception for special pricing may be applied to the identified drugs. To review the Reimbursement Exception Drug List, refer to the “Reimbursement Exception Drug List” linked in Florida Blue Unclassified Drug Payment Policy #10-008.

Claim Payments and Statements

Remittance Advice

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

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

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

If you file electronically, you can receive the 835 ERA upon request. Refer to the Automated 835 Electronic Remittance Advice Enrollment document for additional information on how to start receiving the 835.

Overpayment Recovery

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

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

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

Offsetting Policy

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

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

Timeframe for Requesting Overpayments

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

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

Florida Blue or Florida Blue HMO Identified Overpayments

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

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

We provide advance notification of the intent to recover overpayments by sending a refund request letter. Information contained in the letter includes:

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

Actions to complete upon receipt of the refund request letter

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

Provider Identified Overpayments

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

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

Option 1: Contact the Provider Contact Center

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

Option 2: Refund the overpayment

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

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

Overpayment applies to all claims

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

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

Return Address for Return Checks

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

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

Florida Blue
Lock Box 891213
1501 North Plano RD
Richardson, TX 75081

Clinical Trials Billing

Commercial and Medicare Advantage Clinical Trials

Florida Blue follows CMS billing requirements for Clinical Trials.

For Medicare Advantage members

Clinical Trials covered under the Clinical Trials National Coverage Determination 310.1 (NCD) (NCD manual, Pub. 100-03, Part 4, section 310), original Medicare covers the routine costs.

For all other Florida Blue Members:

Florida Blue will provide coverage on CMS approved Clinical Trials that meet medical necessity.

The following information provides direction to assist with filing the claim:

- Reporting requirements outlined below
- Availity® Companion Guide – Billing requirements
- CMS Claims Processing Manual
- CMS Managed Care Manual
- First Coast Service Options

Note: Medicare Advantage claims: Florida Blue will assess the member liability from the Medicare Explanation of Benefits to ensure cost share is no more than the cost share under the Medicare Advantage Plan.

Reporting Requirements for Institutional Claims

The eight-digit Clinical Trial Number (NCT99999999) is mandatory for all Clinical Trial Claims. See MLN Matters article SE1344 and MLN Matters article 8401 for more details.

Institutional Paper Claim

To add the Clinical Trial number to a paper claim form, add the value amount for "paper only" value code D4 and place the eight-digit number in field locators (FL) 39-41 when a clinical trial includes:

- Condition code 30
- ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only)
- IDE number if applicable billed in

Institutional Electronic Claim

For institutional claims that are submitted on the "Electronic Claim 837I", the eight-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:

- Condition code 30
- ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only)
- IDE number (if applicable)

Reporting Requirements for Professional Claims

The eight-digit Clinical Trial Number (NCT99999999) is mandatory for all Clinical Trial Claims. See MLN Matters article SE1344 or MLN Matters article 8401 for more details.

Note: Professional claims: the eight-digit clinical trial number should be preceded by the two alpha characters of "CT."

Professional Electronic Claims

For Professional claims that are submitted on the "Electronic Claim 837P", the eight-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:

- ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only)
- IDE number (if applicable)

Professional Paper Claims

For Professional claims that are submitted on Paper Claim forms, the eight-digit number should be placed in field locator (FL) 19 when a clinical trial claim includes:

- ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only)
- IDE number (if applicable)