Florida Blue
Your local Blue Cross Blue Shield

Manual for Physicians and Providers

Provider Participation

Plans and Products and ID Cards

Utilization Management

Standing Authorizations

Important Information About the Use of this Manual

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

The Manual is not intended to be a complete statement of polices or procedures for providers. Other policies and procedures, not included in this Manual, may be posted on our website at www.floridablue.com or published in other ways, including but not limited to, letters and bulletins.

Sections of this Manual may be updated at any time. Florida Blue may notify providers of updates in a variety of ways, depending on the nature of the update, including mailings, emails, or postings to our website at www.floridablue.com > Providers (top of the page)> Tools & Resources> News and Announcements.

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

Providers are encouraged to conduct business with us electronically through Availity®[1] whenever possible.

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

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

Important News and Updates

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

Provider Newsletters

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

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

Health Care Reform

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

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

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

Join Our Networks

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

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

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

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

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

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

Our Networks

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

Some of our provider networks may be closed or open only in limited areas. Prior to moving forward, refer to the Network Status Table to determine if we are currently accepting new requests. Refer to your service type to determine if the network is open. If the network for your service type is open, complete the Join our Network request form. If the network is listed as closed, you may check back with us periodically as we are constantly evaluating our networks needs and the open/closed status is subject to change.

Note: Providers must register with us in order to submit a request to participate. If you are not a registered provider, complete the Provider Registration Form. Once registered you may then complete the Join our Network form.

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

Employer Provided Health Plans by County

Individual & Family Health Plans by County

The Credentialing Process

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

We currently use Council for Affordable Quality Healthcare (CAQH) as our preferred method of application data; please ensure that your current CAQH is complete and accurate, as well as currently attested. This will help facilitate the credentialing verification process. We currently utilize a vendor, Medversant, to perform the credentialing verification process. Medversant will access your CAQH application or contact you regarding completion of a manual application if you do not use CAQH. CAQH will make the credentialing and re-credentialing process much easier. If additional application information is needed, you

may be contacted by Medversant on behalf of Florida Blue. Be sure to comply with any response for additional credentialing information timely to ensure the application process is not delayed. We reserve the right to change the vendor we use as we see fit.

Credentialing Requirements for Practitioners

Upon completion of the registration (Provider Registration Form), found on Availity®, you will be given the opportunity to complete a request to Join our Network; this initiates the credentialing process.

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

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

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

Credentialing Requirements for Ancillary, Facility, Supplier Business, and Ambulatory Surgical Centers

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

- Signed attestation statement (within 180 days)
- Copy of Florida license(s)
- Copy of Florida registration
- Current certification of insurance (face sheet with expiration date and coverage amounts) to include errors and omissions for General and Professional liability. If the insurance certificate covers multiple locations, it should either state that all locations owned by the corporate entity are covered OR have a roster of all covered locations attached.
- Explanations for malpractice history and disciplinary actions
- Copy of accreditation documentation, if applicable (ASCs must be accredited)
- If performing MRI, CT, PET, NC (includes cone bean CT)- The Joint Commission, IAC or ACR accreditation is required
- If performing mammography services, ACR Accreditation is Required
- Copy of applicable certification(s)
- Supervising physician statement, if applicable

- Copy of facility medical director's curriculum vitae, medical license, DEA certificate – if applicable
- Copy of Medicare certification(s), if applicable
- Copy of Medicare participation letter, if applicable
- AHCA and/or Centers for Medicare & Medicaid Services (CMS)/Medicare site survey. If not obtained, a Florida Blue site visit is required. (Within 36 months prior to Credential Committee)

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

Credentialing Requirements for Advanced Non-Physician Practitioners (Physician Extenders)

We currently define Advanced Non-Physician Practitioners (ANPP) as Advanced Practice Registered Nurse (APRN), Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS), Licensed Midwife (LMW), Physician Assistant (PA), and Registered Nurse First Assistant (RNFA) who practice independently or as associated members of a physician association.

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

Individually contracted ANPP and individual ANPP practicing under an EIN/tax id where they are the only participating practitioner must be credentialed.

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

Re-credentialing

Re-credentialing is performed every three years or as otherwise required by law or applicable regulations. This requires the submission of an updated credentialing application and documentation. Hospitals are evaluated annually for state license, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation, Det Norske Veritus (DNV) accreditation, Medicare certification, and sanction information. Site visits are conducted for non-accredited hospitals.

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

Updating Application/Documentation

Providers are given the opportunity to review and correct information submitted in support of their application. They will be notified when verified information is inconsistent with what was submitted. Providers must submit the corrected information, in writing, by the date requested. Delays in returning materials may result in closure or termination of your contract(s).

Providers have the right to obtain status of their application. Information shared with providers may include data obtained to evaluate their credentialing application, attestation, or Curriculum Vitae (CV).

Awaiting an Answer

Upon receipt of a complete application, provider credentials are primary source verified according to regulatory body requirements. Once the file has completed the verification process it is forwarded to the Credentialing Committee for review and recommendation. The Credentialing Committee will then make a decision regarding the provider's request for participation with Florida Blue. Each applicant will receive a written response regarding the Credentialing Committee's decision within thirty (30) business days.

Note: If you have completed and submitted all required documentation and haven't received any communication within 90-days, you may contact our Network Management Service Unit area at 1-800-727-2227, who can assist with any questions or concerns you may have**.**

Provider Data and Demographic Maintenance

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

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

Refer to Self-Service Tools for additional information about Availity®.

Proactive and Timely Update of Your Provider Records

As you know, provider demographic data is at the core of doing business with you. It impacts claim payments (timeliness and accuracy) our provider directories (how our members find you) and how you request and receive referrals and authorizations for the care of your patients (our members).

Florida Blue providers are contractually required to report all changes of address or other practice information electronically. Providers must notify us 30-days prior to the effective date of any changes to ensure accurate information is displayed on the provider directory and to avoid impacts to claims processing.

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

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

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

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

Need to Register with Availity®?

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

Our Products

Commercial Products

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

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

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

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

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

Employer Provided Health Plans by County

Individual & Family Health Plans by County

myBlue

myBlue HMO is available to individual Under 65 consumers who are eligible to purchase insurance online through the Health Insurance Exchange. myBlue is a tightly managed and referral-based product that will manage care through a gatekeeper primary care model.

myBlue HMO is different from the existing BlueCare HMO product. myBlue is a traditional HMO plan comprised of a network of Primary Care doctors.

The assigned or affiliated/covering Primary Care doctor directs care including issuing referrals to specialists.

Members can see PCPs within the same group. However, if the PCP is part of a multi-specialty group, the member's assigned or affiliated/covering PCP **must** request a referral for the member **to visit a specialist within the same group.**

myBlue Pharmacy Network

myBlue uses a limited pharmacy network comprised of Walgreens pharmacies. Your patients who are enrolled in myBlue **must** fill prescriptions at a Walgreens pharmacy to avoid paying full cost of their prescriptions. Walgreens has locations in multiple states when urgent/emergent prescriptions or refills are needed.

(See additional information on next page.)

Specific alternative pharmacies are identified for those counties without a Walgreens. Members in the listed counties must fill their prescriptions at the pharmacy indicated in the table to avoid paying full cost.

County	Pharmacy
Calhoun	Golden Pharmacy
Dixie	Cheek Pharmacy
Franklin	Buy Rite Drugs
Gilchrist	Palms Pharmacy
Hardee	Heartland Pharmacy
Holmes	A Plus Pharmacy
Jackson	Kelson Discount Drug
Liberty	Buy Rite Drugs
Madison	North Florida Pharmacy of Madison

myBlue Pharmacy Home Delivery

Prescription medications obtained through home delivery pharmacy services may reduce the cost for your patients on maintenance prescription drugs. Providers should advise the member to review their benefit plan documents to determine if home delivery pharmacy services are included.

Note: If the original prescription was filled at a pharmacy other than the home delivery pharmacy, a new, original prescription, with a quantity of up to a three-month supply and not less than a two-month supply, will be required. Prescriptions may not be transferred from a retail pharmacy to the home delivery pharmacy.

myBlue Referrals

Referrals are required. The assigned or affiliated/covering PCP must issue referrals to specialists. The specialist will need to confirm a referral from the assigned or affiliated/covering PCP is on file by checking Availity® at www.Availity®.com.

Referrals to Hematology and Oncology specialists are valid for six visits within six months from the effective date of the referral.

Referrals to all other specialties are valid for two visits within six months from the effective date of the referral.

Note: If a referral is required for your specialty (exempt list below) and one is not on file, then the myBlue member will not be covered for any services and the member is held harmless.

The following specialties are exempt by legislative law from the referral requirement:

- Obstetrician/gynecologist
    - OB/GYN's serving myBlue members can submit referrals to other specialists when needed, ***if*** the OB/GYN is the assigned PCP for the member.
- Podiatrist
- Chiropractic
- Dermatology (first five visits only)
- Physical Therapy, Occupational Therapy, and Speech Therapy

A referral for behavioral health services is not needed from the myBlue assigned PCP.

The referral is not an authorization for all services. The specialist must obtain authorization to perform services by logging into Availity® at www.Availity®.com.

Refer to the Individual & Family Health Plan by County for myBlue areas.

myBlue Out of Network Services

myBlue does not cover out of network services (except for emergency and urgent care).

myBlue Primary Care Physician Responsibilities

The information below contains references to myBlue specific primary care physician (PCP) responsibilities.

PCP's servicing myBlue members are responsible for managing care through:

- Engaging patients in wellness activities
- Coaching/counseling patients
- Care management through issuance of referrals to specialists and obtaining authorizations for services
- Monitoring patient utilization management
- Developing care management treatment plans
- Contacting patients, assuring scheduled appointments
- Closing patient care gaps
- Monitoring preventive care and disease management, adherence to best practices
- Counseling patients regarding emergency room utilization and arranging follow-up visits
- Contacting members post hospital discharge

myBlue Health Risk Assessment Programs

Quality Engagement Program

The Quality Engagement Program (QEP) focuses on identified Florida Blue members enrolled in an Affordable Care Act *qualified health plan* who have documented chronic conditions that need to be assessed and reconfirmed. Confirmation from a provider in the form of a claim submitted to Florida Blue is required.

QEP outreach to providers occurs by mail at various times during the year. This information is crucial to the patient's clinical quality documentation as well as to the capture of chronic conditions, STARS, HEDIS and new conditions that the physician may not be aware of yet.

QEP action items:

- Contact your patients to schedule an appointment.
- Complete a face-to-face health assessment with your patient and capture any condition assessed or treated within the medical record.
- Submit an encounter claim to Florida Blue with the appropriate diagnosis codes.

Not all myBlue members will be identified and included in QEP information.

Blue Patient Profile (BP2)

A Blue Patient Profile (BP2) is a one-page snapshot developed for each identified member in an Affordable Care Act *qualified health plan* with ICD-10 coding opportunities and STARS/HEDIS care opportunities. BP2 forms will be provided to physicians throughout the year.

BP2 forms are provided to select group levels as well as individual physician levels so they can easily be disseminated across your organization. Providing this member information to physicians assists them in knowing which chronic conditions need to be assessed and coded (when warranted), and it alerts them to STARS/HEDIS measures that need to be addressed.
The key to success when conducting activities related to risk adjustment and quality is the timely access of BP2 profiles so you have access to the information during face-to-face encounters with their patients.

Here are some examples of how you may use the BP2 profiles in your organization:

- Load ICD-10 coding and care opportunities into your Electronic Medical Record (EMR) alert pop-up for each patient so the provider sees them when seeing patients
- Disseminate the individual physician files to the sites where those members are seen.
- Develop an interoffice process that ensures physicians are seeing the BP2 profile at the time of the patient encounter.

Not all myBlue Members will be identified and included in the BP2 program.

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Commercial Products Information Matrix

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

Product Name:	Network	How do members access physician and health care professionals?	Is specialist referral required?	Is the treating physician and/or facility required to give notice when providing certain services?
BlueCare	Florida Blue-HMO	Members choose or are assigned a primary care physician (PCP) for every family member from the network of participating physicians. Member is encouraged to see their PCP to coordinate their care but is not required to obtain a PCP referral when accessing a specialist or facility for care. BlueCare does not cover Out-of-network services (except for emergency care) unless the member has an out-of-network rider with their plan. Authorizations may be required to obtain services covered out of network via the rider.	Referrals are not required for office visits to participating providers. The following physical therapy services are ineligible for payment to participating PCPs when performed in a physician's office: Physical Medicine and Rehabilitation: 97001 – 97546.	Yes, on selected procedures and services, See guidelines in the *Utilization Management* section of this Manual.

Product Name:	Network	How do members access physician and health care professionals?	Is specialist referral required?	Is the treating physician and/or facility required to give notice when providing certain services?
BlueChoice	Florida Blue-Preferred Patient Care (PPC) Traditional/ Payment for Professional Services (PPS) Payment for Hospital Services (PHS) (out of network coverage)	BlueChoice members have open access to any PPC provider without designating a primary care physician. Most BlueChoice plans allow members to seek out-of- network services from providers participating in the Traditional/PPS/PHS network. Covered benefits may be reimbursed at a lower non-participating level. Participating Traditional/PPS/PHS are considered out-of-network for PPC members, however, you may not balance bill the member.	No, referrals to specialists are not required.	
BlueOptions	NetworkBlue-PPO Traditional/ Payment for Professional Services (PPS) Payment for Hospital Services (PHS) (out of network coverage)	BlueOptions members have open access to any PPC provider without designating a primary care physician. Most BlueOptions plans allow members to seek out-of- network services from providers participating in the Traditional/PPS/PHS network. Covered benefits may be reimbursed at a lower non-participating level. Participating Traditional/PPS/PHS providers are considered out-of-network for PPC members, however, you may not balance bill the member.	No, referrals to specialists are not required.	Yes, on selected procedures and services, See guidelines in the *Utilization Management* section of this Manual.

Product Name:	Network	How do members access physician and health care professionals?	Is specialist referral required?	Is the treating physician and/or facility required to give notice when providing certain services?
myBlue myBlue uses a subgroup of our BlueCare® HMO (Health Options, Inc.) primary care physician and specialist network.	Florida Blue – HMO	Members choose or are assigned a primary care physician (PCP) for every family member from the network of participating physicians. Members are required to visit their assigned PCP (or another PCP participating within the same group) to coordinate their care. Authorizations for most services are required	Referrals are required and assigned or affiliated/covering PCPs must issue referrals to specialists. The specialist will need to confirm a referral from the assigned or affiliated/covering PCP is on file by checking Availity® at www.Availity®.com. Referrals to Hematology and Oncology specialists are valid for 6 visits within 6 months from the effective date of the referral. Referrals to all other specialties are valid for 2 visits within 6 months from the effective date of the referral. **Important:** If a referral is required for your specialty (exempt list) and one is not on file, then the myBlue member will not be covered for any services and the member is held harmless.	Yes, for most procedures and services, except for services that have a standing authorization. See guidelines for authorizations and standing authorizations

Product Name:	Network	How do members access physician and health care professionals?	Is specialist referral required?	Is the treating physician and/or facility required to give notice when providing certain services?
Traditional PPS/PHS	Payment for Professional Services (PPS) Payment for Hospital Services PHS)/Traditional	Traditional PPS/PHS members have open access to any BlueSelect provider without designating a primary care physician. Members may receive care from providers who participate in Florida Blue networks but may be subject to higher out-of-pocket costs. Members also have access to the Traditional/PPS/PHS network. When members access Traditional/PPS/PHS providers, covered benefits are usually reimbursed at a lower level and their coinsurance percentage is higher. As a participating Traditional/PPS/PHS network provider, you may not balance bill the member.	No, referrals to specialists are not required.	

Product Name:	Network	How do members access physician and health care professionals?	Is specialist referral required?	Is the treating physician and/or facility required to give notice when providing certain services?
BlueSelect	BlueSelect	BlueSelect members have open access to any BlueSelect provider without designating a primary care physician. However certain services are subject to an Exclusive Provider Organization (EPO) provision and are only covered when rendered by providers designated by us as the exclusive provider for such service. Services that may be subject to the EPO provision are: Behavioral Health Dental services Durable Medical Equipment Home health/home infusion Laboratory Medical Supplies Orthotics/prosthetics Pharmacy Vision Services Participating Traditional (PPS/PHS) hospitals and facilities are considered out-of-network for BlueSelect members, and there is no balance billing protection.	No, referrals to specialists are not required.	Yes, on selected procedures and services, See guidelines in the *Utilization Management* section of this Manual.

Product Name:	Network	How do members access physician and health care professionals?	Is specialist referral required?	Is the treating physician and/or facility required to give notice when providing certain services?
SimplyBlue SimplyBlue uses a subgroup of our BlueCare® HMO (Health Options, Inc.) primary care physician and specialist network.	Florida Blue – HMO All BlueCare HMO providers in the counties where the new product is available can see SimplyBlue members unless they receive a letter from Florida Blue notifying them that they are not participating with SimplyBlue.	Members choose or are assigned a primary care physician (PCP) for every family member from the network of participating physicians. Member is encouraged to see their PCP to coordinate their care, but is not required To obtain PCP referral when accessing a specialist or facility for care. SimplyBlue does not cover Out-of-network services. (except for emergency care)	Referrals are not required for office visits to participating providers. The following physical therapy services are ineligible for payment to participating PCPs when performed in a physician's office: Physical Medicine and Rehabilitation: 97001 – 97546.	Yes, on selected services. See guidelines *Utilization Management* section of this Manual.

Enhanced BlueOptions & BlueSelect Temporary Insurance Plans

Florida Blue provides enhanced temporary insurance plans on the BlueOptions and BlueSelect networks. These plans are targeted for members looking to fill gaps between coverage or members who no longer can afford an Affordable Care Act (ACA) plan.

Keep in mind: Temporary insurance plans do not have the same level of coverage as ACA plans. A key difference is temporary insurance plans do not provide coverage for pre-existing conditions a member had within 24 months of their plans effective date. Be sure to verify a member's benefits and eligibility electronically through Availity® at Availity®.com.

For more information on the BlueOptions and BlueSelect temporary insurance plans please access the Health Care Plans (Temporary Insurance) on our website. You will find additional information located in the Bulletins and FAQ's at www.FloridaBlue.com.

Temporary insurance plans are available in counties where BlueOptions and BlueSelect are available for sale. More information provided here.

Federal Employee Plan (FEP) Plan Options

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

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

Additional information regarding FEP can be found at http://fepblue.org.

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

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

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

Product Name:	Network	How do members access physician and health care professionals?	Is specialist referral required?	Is the treating physician and/or facility required to give notice when providing certain services?
FEP Basic Option	Florida Blue-PPC	• FEP Basic Option members have open access to any PPC provider without designating a primary care physician. • FEP Basic Option members must use PPC providers to receive benefits. The plan does not allow members to seek out-of- network services except under special emergent circumstances. • Participating Traditional/PPS/PHS are considered out-of-network for PPC members. There is no balance billing protection for out-of-network services.	No, referrals to specialists are not required.	Yes, on selected procedures and services, See guidelines in the *Utilization Management* section of this Manual.

Product Name:	Network	How do members access physician and health care professionals?	Is specialist referral required?	Is the treating physician and/or facility required to give notice when providing certain services?
FEP Blue Focus	Florida Blue-PPC	• FEP Blue Focus members have open access to any PPC provider without designating a primary care physician. • FEP Blue Focus members must use PPC providers to receive benefits. The plan does not allow members to seek out-of- network services except under special emergent circumstances. • Participating Traditional/PPS/PHS are considered out-of-network for PPC members. There is no balance billing protection for out-of-network services.	No, referrals to specialists are not required.	Yes, on selected procedures and services, See guidelines in the *Utilization Management* section of this Manual

State Employee PPO

Prefix: XJJ

In-Network: NetworkBlue BlueOptions

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

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

The preferred provider network for State Employees' Standard PPO and High Deductible Health PPO plans is NetworkBlue. Members may seek care from providers in their network, NetworkBlue, Traditional/PPS/PHS network providers, or non-network providers. BCBSF will make the payment directly to the provider for covered services.

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

Additional information regarding State Employees' PPO Plans can be found at www.FloridaBlue.com/state-employees.

Medicare Products

Florida Blue operates as a Medicare Advantage Organization and has members enrolled in both Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO) lines of business. Florida Blue Medicare Advantage products include HMO: Classic, Classic Plus, Premier, Complete and Saver; PPO: Choice, Select, Value and Patriot, and BlueMedicare Group PPO.

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

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

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

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

MedAdvantage/BlueMedicare HMO/PPO Product

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

Product Name	Network (s)	How do members access physician and health care professionals?	Is a specialist referral required?	Are the treating physician and/or facility required to receive authorization when providing services?
BlueMedicare Group PPO	Medicare Advantage PPO (MAPPO) Medicare Advantage PPO (MAPPO) Network Sharing (out- of- state)	BlueMedicare Group PPO members have open access to any Med-Advantage PPO provider without designating a Physician of Choice. BlueMedicare Group PPO allows members to seek out-of-network services. Providers that do not accept Medicare assignment cannot bill member greater than 15% over the allowed amount unless the provider has completely opted out of the Medicare program.	No, referrals to specialists are not required.	Yes, on selected procedures and services, See guidelines in the *Utilization Management* section of this Manual.

Product Name	Network (s)	How do members access physician and health care professionals?	Is a specialist referral required?	Are the treating physician and/or facility required to receive authorization when providing services?
BlueMedicare Choice	Medicare Advantage PPO (MAPPO) Medicare Advantage (MAPPO) Network Sharing (out- of- state	BlueMedicare Choice members have open access to any Med-Advantage PPO provider without designating a Physician of Choice. BlueMedicare Choice allows members to seek out-of-network services. Providers that do not accept Medicare assignment cannot bill member greater than 15% over the allowed amount unless the provider has completely opted out of the Medicare program.	No, referrals to specialists are not required.	Yes, on selected procedures and services, See guidelines in the *Utilization Management* section of this Manual.

Product Name	Network (s)	How do members access physician and health care professionals?	Is a specialist referral required?	Are the treating physician and/or facility required to receive authorization when providing services?
BlueMedicare Select/ BlueMedicare Value PPO/ BlueMedicare Patriot PPO	Medicare Advantage (MAPPO) Medicare Advantage PPO (MAPPO) Network Sharing (out- of- state	BlueMedicare Select, BlueMedicare Value and BlueMedicare Patriot PPO members have open access to any Med-Advantage PPO provider without designating a primary care physician. BlueMedicare Select, BlueMedicare Value, and BlueMedicare Patriot PPO allows members to seek out-of-network services. Providers that do not accept Medicare assignment cannot bill member greater than 15% over the allowed amount unless the provider has completely opted out of the Medicare program.	No, referrals to specialists are not required.	Yes, on selected procedures and services, See guidelines in the *Utilization Management* section of this Manual.
BlueMedicare HMO (Classic, Classic Plus, Premier, Complete, Saver) (Cont'd next page)	BlueMedicare HMO (MM) (Medicare Advantage MAHMO)	Members choose or are assigned a Primary Care Provider (PCP) from the network of participating physicians. Members are required to see their assigned PCP to coordinate their care.	Yes, referrals to specialists are required.	Yes, on selected procedures and services, See guidelines in the *Utilization Management* section of this Manual.

BlueMedicare HMO (Classic, Classic Plus, Premier, Complete, Saver)	(Cont'd from previous page) BlueMedicare HMO (MM) (Medicare Advantage MAHMO)	Only a Blue Medicare HMO member assigned or selected primary care physician can issue a referral. Providers must make sure this is done **before** services are provided to the member. You can verify if a referral is on file electronically through Availity®1 at Availity®.com. Blue Medicare HMO primary care physicians are responsible for issuing referrals to specialists. Primary care physicians who are part of a multi-specialty group must issue a referral for a Medicare Advantage HMO member to visit a specialist within the same group. Important: Blue Medicare HMO members must have a referral and/or authorization on file. If an authorization or referral is required and one is not on file, then the services may not be covered. BlueMedicare HMO does not cover out-of-network benefits (except for emergency and urgent care, dialysis services, or services specifically authorized).		

About National and Local Coverage Determinations for BlueMedicare[SM] Members

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

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

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

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

Physicians and other providers are responsible for understanding whether specific items and services are covered under Original Medicare and, therefore, also covered by our Medicare Advantage plans. A member's eligibility and benefits may be verified electronically through Availity®[1] at Availity®.com. If there is uncertainty regarding whether a particular service requested by a member is covered under Medicare, the provider or the member may request a pre-service "Organization Determination" from the plan. You may also request a pre-service "Organization Determination" for issues related to referrals.

If the pre-service Organization Determination is **denied** and the provider still renders the service, the claim must be billed using a -GA modifier (indicating a waiver of liability statement, known as an Integrated Denial Notice (IDN) for Medicare Advantage plans, was issued by the provider in advance, as required by plan guidelines).

The -GA modifier may only be billed if both an adverse Organization Determination was received and the member's signature is on file in the provider's record, indicating that the member was advised in advance of the service and clearly understands that it is not covered and that he/she has agreed to be responsible for the cost of the service. If the provider did not obtain the IDN in advance of providing a non-covered service, then the member may not be billed for that service.

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

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

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

- The CMS Medicare Coverage Database for information about NCD and LCD guidelines applicable to services rendered in Florida. These guidelines can be found at www.cms.gov.
- First Coast Service Options - Medicare LCD at http:\\medicare.fcso.com for information about LCD guidelines.
- Florida Blue evidence-based Medical Policies (Medical Coverage Guidelines) at http://mcgs.bcbsfl.com/.

Medicare Advantage- Blue Medicare

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

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

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

The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits.

BlueMedicare HMO members are permitted under their Medicare benefits to see the following kinds of participating specialists /providers for plan-covered services without first obtaining a referral:

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

Emergency Care

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

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

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

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

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

Medicare Supplement Products-Advantage 65

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

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

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

Blue Medicare Saver HMO

The new BlueMedicare Saver HMO, effective 1/1/2020, is a narrow network product offered in Broward, Hillsborough, Miami-Dade, Orange, Osceola, Pinellas, and Polk counties. Florida Blue Medicare will return part of the member’s Part B premium each month through coordination at The Social Security Administration. Amounts vary per county from $50 to $80 per month. The product will have our limited Primary Care Provider (PCP) network that will utilize providers who participate in risk arrangements to improve patient outcomes. This narrow PCP network will utilize the existing BlueMedicare HMO Specialists, Hospitals and Ancillary Networks which are contracted through the Health Options, Inc. (HOI) agreement. The PCP network will be comprised of a few providers and physician entities (MSO, IPAs, and Staff Model Practices) experienced in managing a Medicare population, and will assume full Part A, B and D financial risk for their assigned population. See the Medicare ID Card Section, page 48, for an example of the member ID card. The product will have PCP assignment and referrals for specialist/facility services will be managed by the PCP. BlueMedicare Saver HMO is contracted so that although the group is par with the network, only select PCPs within the group will be considered participating in this product.

Blue Medicare Premier HMO

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

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

The PCPs and physician entities will include some Florida Blue existing Collaborative Care Model and Full Risk partners (e.g., Inter-American Medical Centers (IMC) and Baptist Health South Florida (BHSF) as well as new partners). The product will have PCP assignment and referrals for specialist/facility services will be

managed by the PCP. BlueMedicare Premier HMO is contracted so that although the group is par with the network, only select PCPs within the group will be considered participating in this product.

Important things to remember:

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

Global Plans for Group Business

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

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

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

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

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

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

Global Plans for Canadian Business

Blue Canadian Travel Insurance

BCBS Global Canadian Traveler – Short term plans that provide supplemental medical benefits and services for Canadian travelers.

- Travelers are covered for services resulting from an accident, medical emergency, or sudden illness, including hospitalization and medical repatriation and evacuation.
- Additional riders available – spouse/dependent coverage

Utilization Management for Blue Canadian Travel Insurance

Call Canadian assistance for pre-approval of all medical services as follows:

- Canada: 1-833-929-0903

All other CanAssistance general inquiries related to claim as follows:

- 1-800-727-2227

Blue TPA Canadian Travel Insurance

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

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

Benefit Information

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

Utilization Management for Blue TPA Canadian Travel Insurance
Call Canadian assistance *for pre-approval of all medical services* as follows:

- Canada: 1-800-361-6068.

All other CanAssistance inquiries as follows:

- FloridaProvider@canassistance.com
- 1-800-995-1683

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

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

Contact Us

The Contact Us page at www.floridablue.com provides updated contact information for Florida Blue and Florida Blue Partners.

Contingency Plan for Emergencies and Natural Disasters

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

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

Health Care Identification Cards

We offer a variety of product lines to meet the health care coverage needs of our members. Just like a credit card, the member's ID card can be swiped through a card reader to access real-time eligibility and benefit information via Availity® that also provides access to Patient Cost Estimator, Availity® Care Profile and other online capabilities.

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

ID Cards

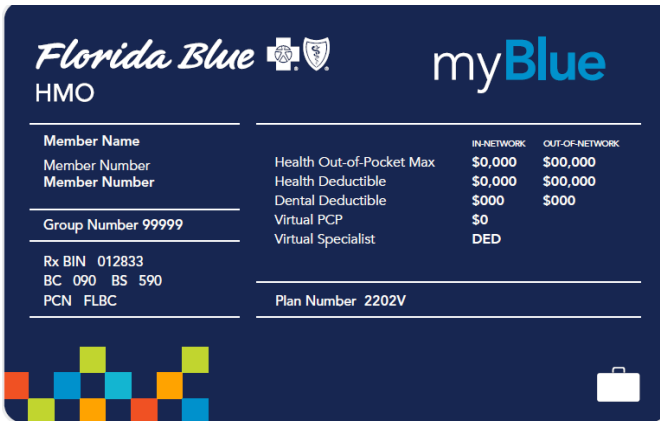
BlueCare - HMO

BlueChoice

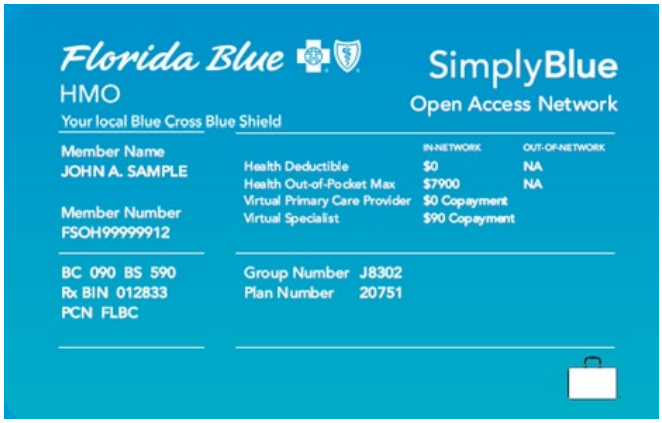
BlueOptions – NetworkBlue

BlueSelect

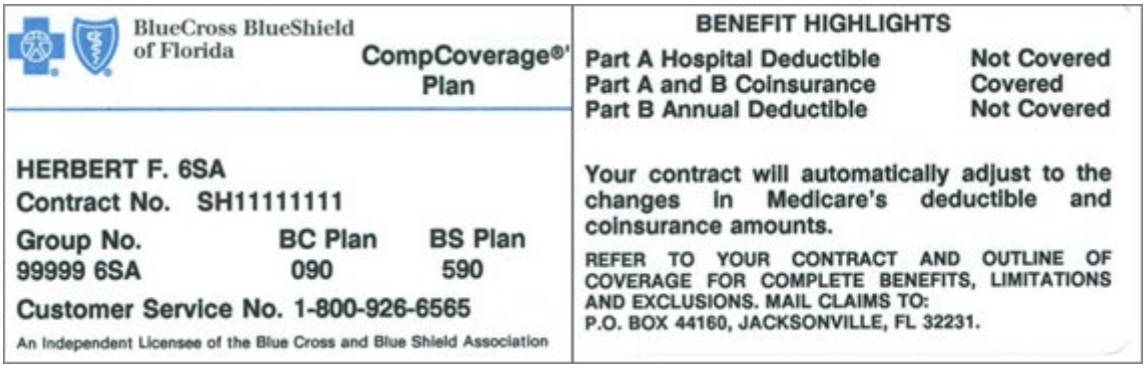
myBlue



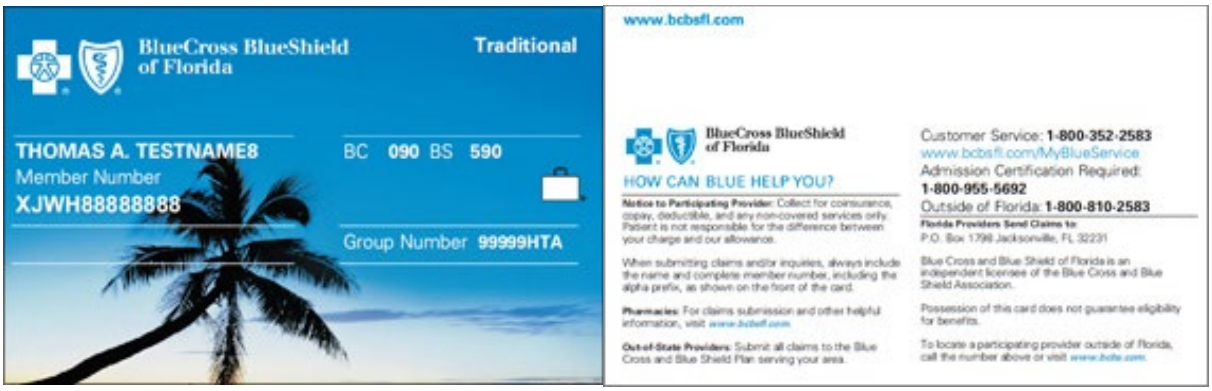
Simply Blue



CompCoverage (A, B, C, D, F)

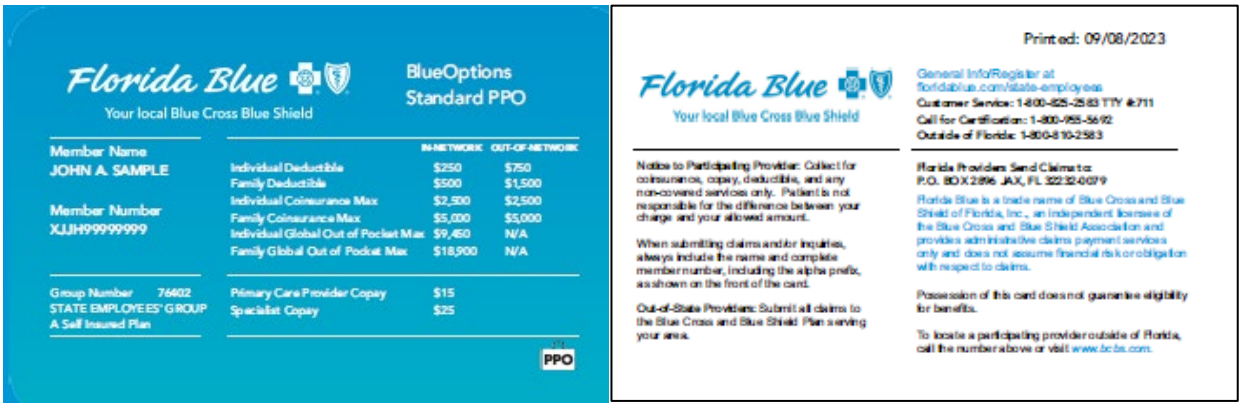


Traditional (PPS/PHS)

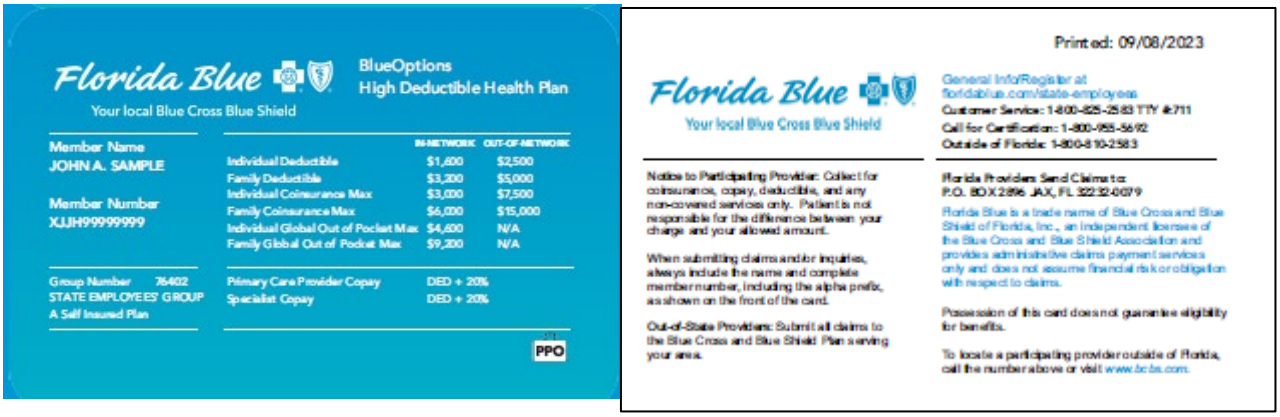


State Employee ID

State Employee Standard PPO ID *(Please note: dollar values sjubject to change each year.)*

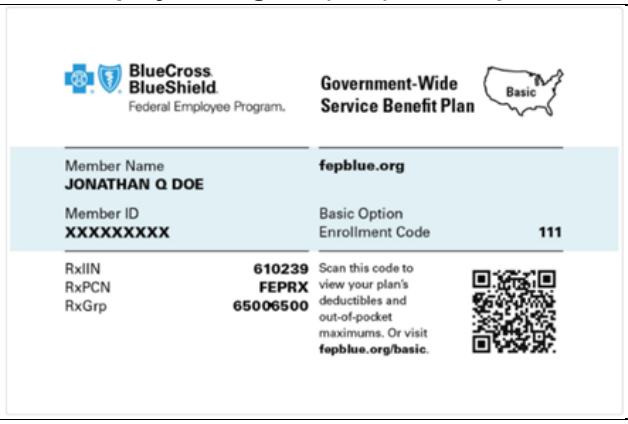


State Employee HDHP PPO *(Please note: dollar values subject to change each year.)*

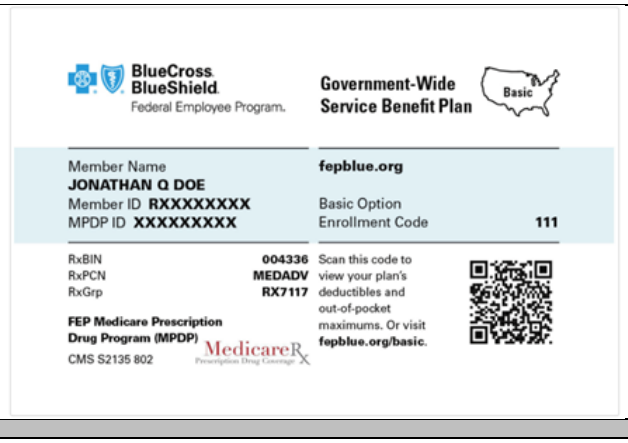


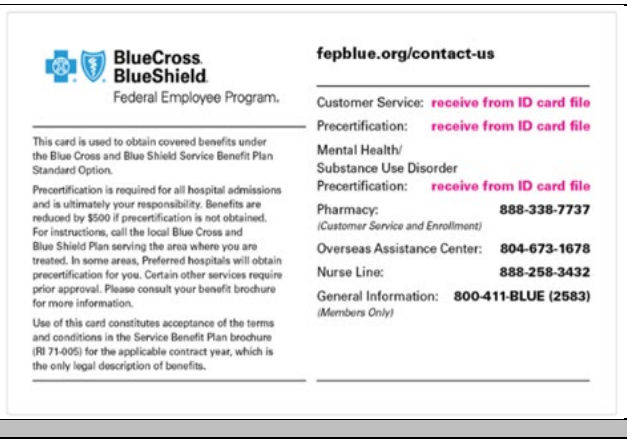
Federal Employee Program

Federal Employee Program (FEP) Basic Option

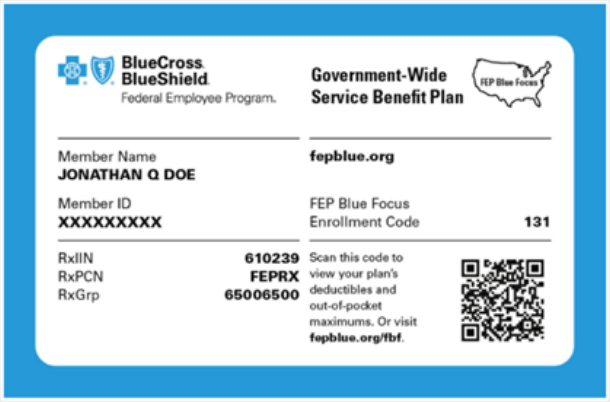


Federal Employee Program (FEP) Basic Option with Medicare Prescription Drug Program (MPDP)

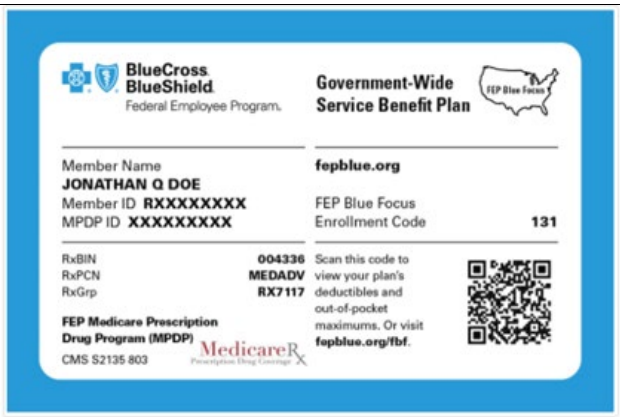


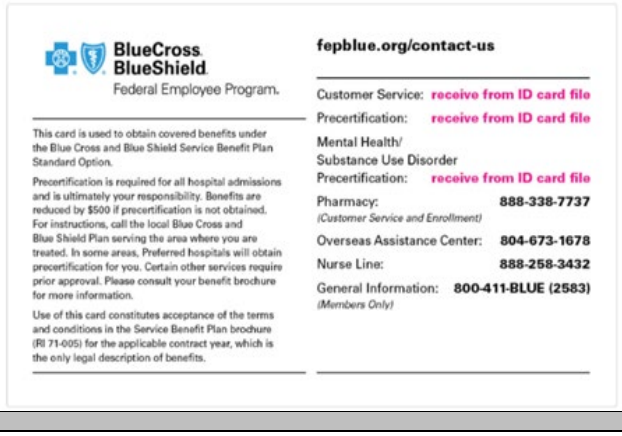


Federal Employee Program (FEP) Blue Focus



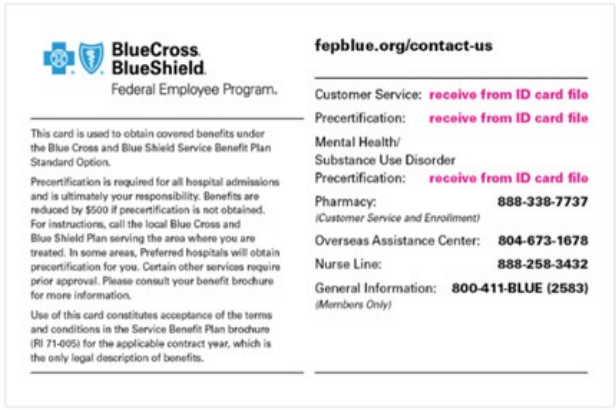
Federal Employee Program (FEP) Blue Focus Medicare Prescription Drug Program (MPDP)





Federal Employee Program (FEP) Standard Option

Federal Employee Program (FEP) Standard Option with Medicare Prescription Drug Program (MPDP)

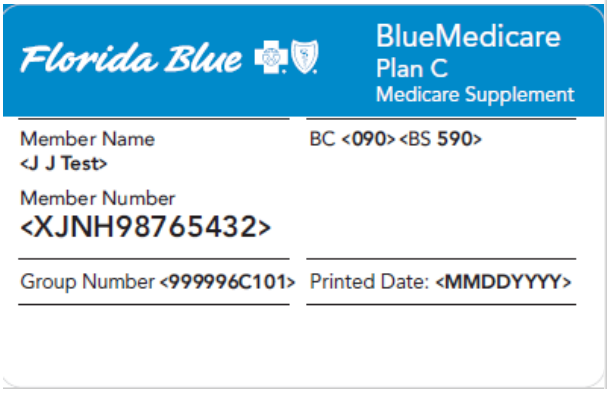


Medicare ID Cards

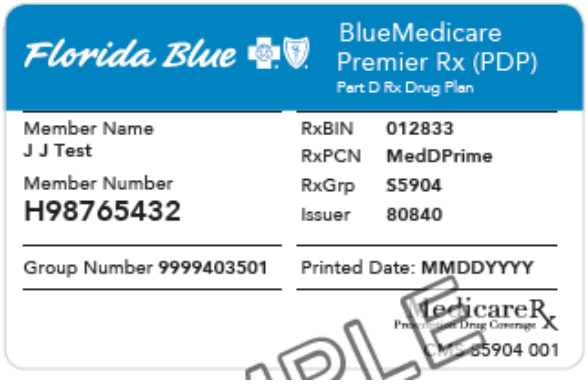
Our Medicare Advantage and Medicare Supplement members receive a health care ID card designed to help you access our automated phone or online systems to verify benefits, eligibility and claim status. Each health care ID card includes a unique identifier that designates the Medicare Advantage or Medicare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

Medicare Supplement-Advantage 65 ID Cards

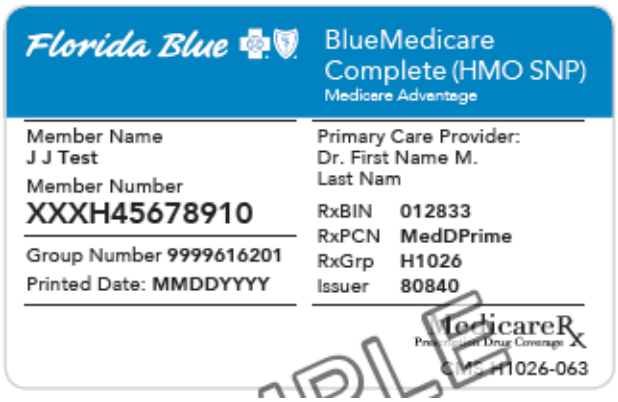
BlueMedicare Supplement



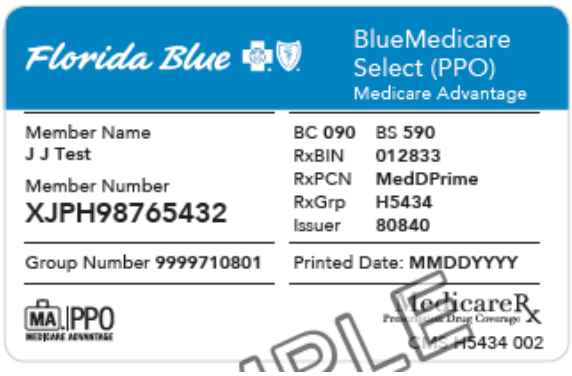
BlueMedicare Premier Rx ID Cards



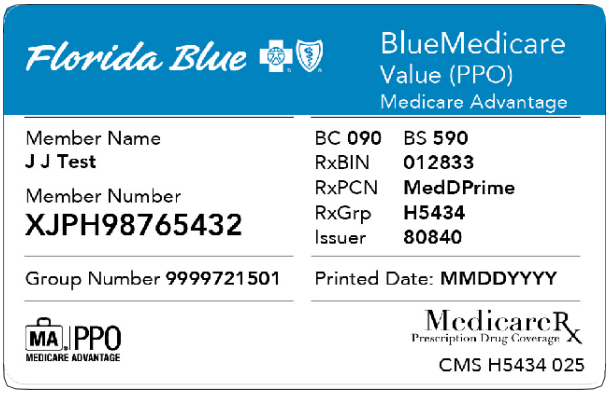
BlueMedicare Complete Rx ID Cards

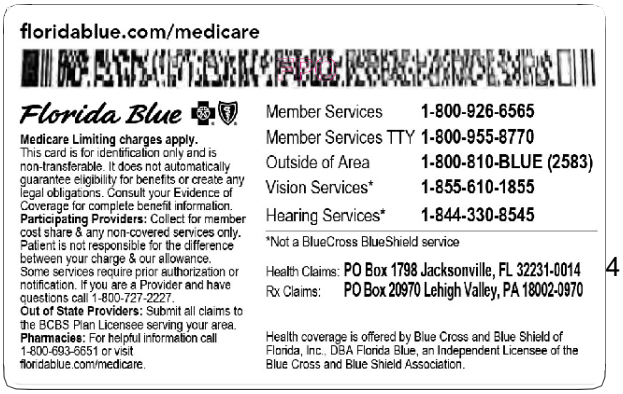


BlueMedicare Select ID Cards

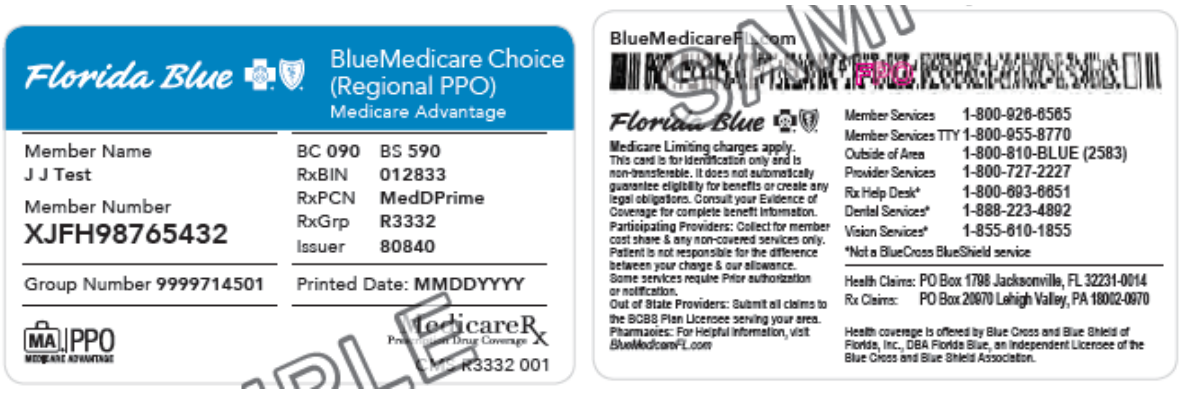


BlueMedicare Value ID Card

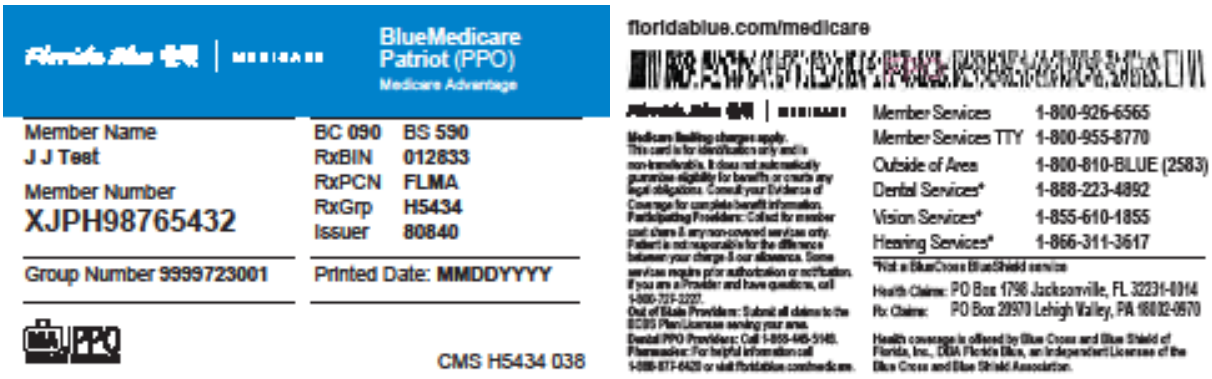




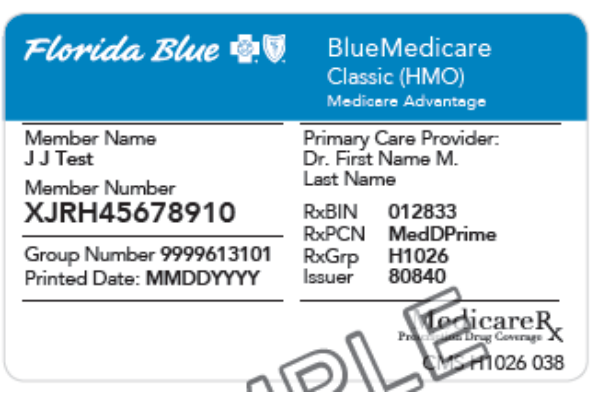
BlueMedicare Choice ID Card

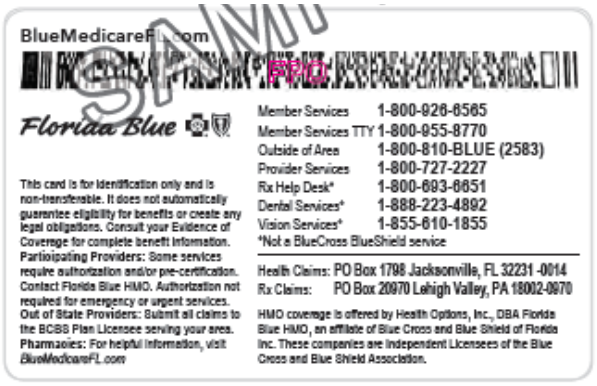


BlueMedicare Patriot ID Card

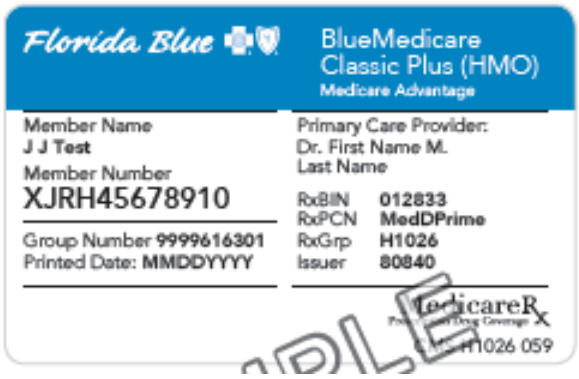


BlueMedicare Classic HMO ID Card

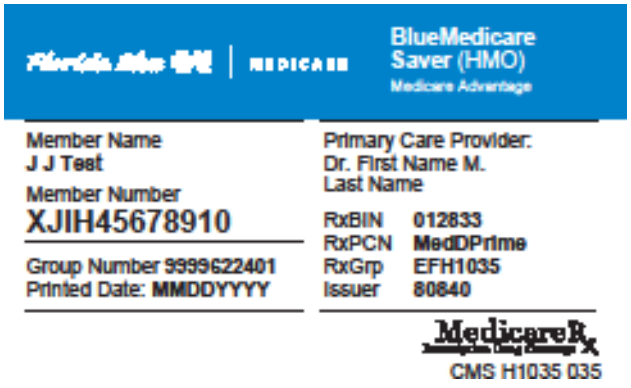




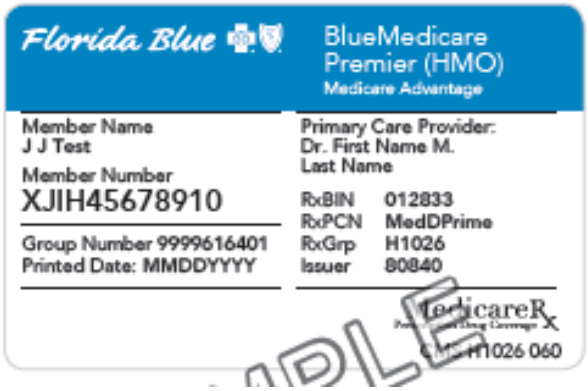
BlueMedicare Classic Plus HMO ID Card



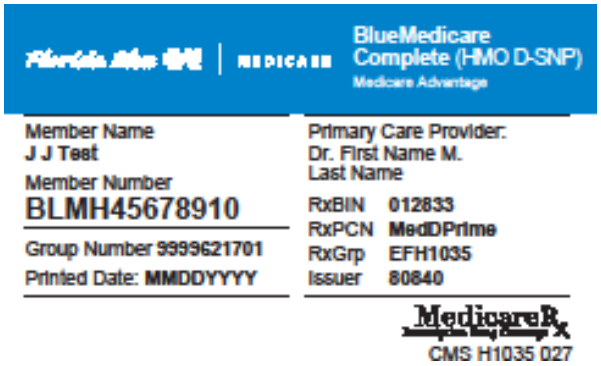
BlueMedicare Saver HMO



Blue Medicare Premier HMO



BlueMedicare Complete (HMO D-SNP)



Utilization Management Programs

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

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

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

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

This includes:

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

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

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

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

Medical Policies, Medical Coverage Guidelines (MCG)

We process claims based on the member's eligibility, benefits, and the medical necessity of the service provided. Evidence-based Medical Policies (Medical Coverage Guidelines) are used to help determine coverage under the medical necessity provisions of member contracts and Certificates of Coverage. In developing its Medical Policies (Medical Coverage Guidelines), we look to current best available external clinical evidence, specialty societies, physician consultants, the Food and Drug Administration FDA, and the BlueCross BlueShield Association.
Note: CMS establishes its own medical guidelines mandated by law for Medicare beneficiaries. Although the criteria for reviewing services may be similar, the Medicare medical guidelines and our Medical Policies (Medical Coverage Guidelines) are not interchangeable.

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

Certificates of Medical Necessity (CMN)

To expedite the medical review process for certain requests, we provide Certificate of Medical Necessity (CMN) forms to our Providers. Each CMN is associated with one of our Medical Coverage Guidelines (MCG). CMNs offer Providers a way to attest to information within a member's medical documentation, rather than requiring the Provider to send that documentation to us.
Additionally, a blue document symbol will appear in the top left corner of each associated MCG following the 9-digit MCG policy number. This indicates an MCG has an associated CMN. Information about each CMN is in the Position Statement section in each MCG.

Pre-Service Medical Review Fax Cover Sheet

Clinical Operations Programs

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

Concurrent Review

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

Case Management

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

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

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

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

Facility/Physician Disease and Case Management Programs

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

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

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

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

Chronic Conditions - Disease Management

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

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

Chronic Kidney Disease and End Stage Renal Disease

Florida Blue Medicare has engaged Healthmap Solutions, Inc to manage our member's Chronic Kidney Disease/End Stage Renal Disease Program (Stage 3b – 5) starting on May 1, 2021. Florida Blue Medicare is working with Healthmap Solutions, Inc. to integrate data and evidence-based clinical expertise to help improve your patient's kidney Health. The KHM Program Goals for Florida Blue Medicare Advantage patients are as follows:

- Improve patient's health outcomes and lower costs through early identification of patients with chronic kidney disease (CKD)
- Relieve your administrative burden by integrating clinical insights into your current kidney disease management practice workflows
- Identify the appropriate renal replacement therapy (home dialysis or transplant) for end stage renal disease (ESRD) patients

This program is available to Florida Blue Medicare Advantage HMO and PPO patients who have, or are at risk for, chronic kidney disease (CKD). Blue Cross and Blue Shield members from plans other than

Florida blue are not eligible for the program. Eligible patients are identified based on a predictive model that considers the CKD stage, comorbidities, historical costs of care and social determinants of health. A Healthmap Provider Relationship Manager (PRM) will contact providers to ask them to collaborate in the care prior to their patient's engagement in the program.

Delegated Case Management for Behavioral Health Services

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

High Risk Maternity Program

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

Medicare Advantage Care Programs

Individuals with Complex or Chronic Health Conditions may benefit from one of our Florida Blue Medicare Care Programs. Our nurses and care team staff can assist members who have serious health problems access covered services under their health benefit plan. They also help identify community resources that may assist members and their families. These programs are voluntary and offered at no additional cost to members with Florida Blue health plan coverage.

For additional information about the Florida Blue Medicare Care Programs, you may call 800-955-5692 option 1, then option 2. Please use the FloridaBlue Medicare Clinical Care Referral Form to request services.

Outline of Programs and Services	
Case Management:	
Complex Case Management	Targeted telephonic outreach to members with multiple chronic conditions.
Catastrophic Case Management	Targeted telephonic outreach to members with catastrophic illness or injury.
Integrated Behavioral Case Management	Targeted outreach to members with behavioral health and chronic medical conditions
Readmission Prevention	Census based telephonic outreach or in-home visit to members with high risk for facility readmissions.
Supportive Care Case Management	Short-term case management program designed to provide members who would benefit from palliative care education and assistance with enrollment in a palliative care program.
Disease Management:	
Health Management program	Targeted outreach to members with one chronic condition. Team includes Registered Dietitian/Nutritionist, Respiratory Therapist, Certified Diabetic Educator/RN, and Health Coaches.
Community Health:	
Community Health Specialist Program	Community telephonic outreach or in-home assistance to members who have social determinants of health or other barriers to achieving wellness.

(continued on next page)

Member Engagement:	
Discharge Outreach Program	Census based telephonic outreach to members discharging from a facility to ensure compliance with discharge plan and avoid readmissions.
Member Outreach Program	Intake call support and telephonic outreach to engage new or previously hard to engage members.

Neonatal Intensive Care Unit

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

Pediatric Care Program

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

PATCH (Physician Assessment, Treatment, and Consultations at Home) Utilization Program

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

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

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

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

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

South Network - Dade, Broward, and Palm Beach

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

Members are referred into the program in several ways. The following information provides a list of ways in which members are referred.

Attending physician

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

Directly to PATCH Program providers

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

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

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

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

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

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

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

PATCH – Contracted Provider Responsibilities

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

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

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

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

Program Recap

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

Utilization Management by Products and Network

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

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

This includes but is not limited for the following:

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

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

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

Utilization Management Table by Commercial Product & Network

Service	Network – Product	Contractual Obligation
Advanced Imaging (CT Scans, MRIs/MRAs, PET Scans, Nuclear Medicine) **FEP Plans** do not require authorizations for Advanced Imaging. *See (Appendix J) for list of procedures or more detailed clinical guidelines.*	BlueCare – HMO myBlue – HMO SimplyBlue - HMO	Authorizations are required and should be requested via Availity®
	BlueChoice - PPC/PPO Traditional - PPS/PHS	Authorization, certification, or notification is not required.
	BlueOptions - NetworkBlue BlueSelect	Authorizations are required and should be requested via Availity®
	Fully Insured, ACA Compliant Large Group BlueChoice – PPC Traditional – PPS/PHS	Authorizations are required and should be requested via Availity®
	State Employee PPO - NetworkBlue PPO	Authorization, certification, or notification not required
Ambulance	BlueCare - HMO myBlue - HMO SimplyBlue - HMO	Authorization required for non-emergency transport only.
Behavioral Health Services Authorizations are required and should be requested from Lucet Behavioral Health **Note**: Psychologists, mental health clinicians, LCSWs, LMHCs, MFTs, and BCBAs are behavioral health services provided to Florida Blue members.	BlueCare – HMO myBlue - HMO SimplyBlue - HMO BlueSelect FEP Blue Focus – PPC/PPO	**Inpatient:** All inpatient psychiatric and substance abuse admissions require authorization by the admitting facility. **Outpatient:** Behavioral health services are managed. Authorizations for some members may be required. Partial hospitalization, IOP and Substance Abuse Rehabilitation: Require authorizations and must be coordinated.
	BlueChoice – PPC/PPO BlueOptions - NetworkBlue Traditional - PPS PHS Certification should occur within one business day of admission.	**Inpatient:** Certification required for psychiatric and substance abuse facilities. **Outpatient:** Authorization may be required for some members.

Service	Network – Product	Contractual Obligation
Behavioral Health Services	FEP Basic - PPC/PPO FEP Standard - PPC/PPO	**Inpatient:** Preadmission certification required for psychiatric and substance hospitals. $500 penalty applies if precertification is not obtained. **Outpatient:** Prior approval is not required to receive mental health and/or substance abuse to include partial psychiatric, intensive outpatient or outpatient professional or outpatient facility care. **Note:** Does not include coverage for applied behavioral analyst. Please access Availity® for services and network information.
Birthing Centers	BlueCare – HMO myBlue – HMO SimplyBlue - HMO	Submit authorization requests electronically through Availity®
Certified Nurse Midwife	BlueCare – HMO myBlue – HMO SimplyBlue – HMO	Submit authorization requests electronically through Availity®
Cardiology Services	Large Group (Non-grandfathered): BlueOptions – NetworkBlue BlueCare – HMO BlueChoice – PPO Small Group ACA: BlueOptions – NetworkBlue BlueCare – HMO SimplyBlue – HMO BlueSelect Individual ACA: BlueOptions – NetworkBlue BlueCare – HMO BlueSelect myBlue – HMO	For specific Diagnostic Cardiology Test codes that do NOT require an authorization, please see the "Standing Authorization" section of this provider manual. For all other Cardiology codes, submit authorization requests electronically through Availity® based on the location of service.

Service	Network – Product	Contractual Obligation
Chemotherapy Refer to Medical Pharmacy list for the specific drugs that requires prior approval.	State Employee PPO BlueOptions – NetworkBlue PPO BlueChoice – PPO BlueCare – HMO myBlue – HMO SimplyBlue – HMO BlueSelect FEP	Prior approval required if participating in the PADP. Refer to Magellan RX Management
Clinical Education	BlueCare – HMO	Authorization required.
Chiropractic Chiropractic providers participating in the American Specialty Health, ASH network should call 800-972-4226. All services are subject to medical necessity review.	BlueCare – HMO myBlue – HMO SimplyBlue – HMO BlueOptions – NetworkBlue BlueSelect Exchange Products BlueMedicare HMO BlueMedicare PPO BlueChoice ***Exception: FEP and SAO*** which DOES NOT require utilization review/authorization by ASH)	The following functions will be managed by American Specialty Health (ASH): • Provider Contracting & Credentialing • Utilization Management • Claims Processing • Provider Payment • Provider Services • Provider Appeals • Coordination of Benefits
Dialysis	BlueCare – HMO myBlue – HMO SimplyBlue – HMO	Authorization required. Submit authorization requests electronically through Availity®
Durable Medical Equipment Florida Blue's exclusive provider for these services must be requested through CareCentrix at 877-561-9910, by fax at 877-627-6688, or online through the CareCentrix web portal.	BlueCare – HMO myBlue – HMO SimplyBlue – HMO BlueChoice – PPC/PPO BlueOptions – NetworkBlue	Authorization is required for all DME and MS needs.
	Blue Select	For Blue Select and BlueCare members based on medical appropriateness for a condition, some DME and medical supplies do not require a prior authorization when a participating provider supplies the items. See our standing authorization section.
Hip & Knee	BlueCare – HMO myBlue – HMO SimplyBlue – HMO Individual ACA – BlueSelect Individual ACA – BlueOptions – (NetworkBlue)	Authorizations will be handled by Florida Blue. Please submit your authorization requests via Availity®. See (Appendix D) for a list of procedures. Cosmetic, plastic, or reconstructive surgery is subject to medical necessity review.

Service	Network – Product	Contractual Obligation
Home Health/Home Infusion Florida Blue's exclusive provider for these services must be requested through CareCentrix at 877-561-9910, by fax at 877-627-6688 or online through the CareCentrix web portal. .	BlueCare – HMO myBlue – HMO SimplyBlue – HMO BlueChoice – PPC/PPO BlueOptions – NetworkBlue PPO Traditional – PPS/PHS BlueSelect	Authorization is required for all Home Health services. All authorizations are to be requested through CareCentrix **Note** – For providers not included in CareCentrix network, authorization is required through Florida Blue
Hospice If the services on the claim are not the same as those authorized, the claim will be held for review of more information. For BlueSelect, if timely notification is not made by a facility of an inpatient admission or if no notification is made, a financial penalty may be imposed of 20 percent of the total claim for an episode of care that would have otherwise been due to the inpatient facility under the Agreement then in effect if provider notification had been provided (regardless of payment methodology defined within the provider Agreement) up to a maximum of $500, for each BlueSelect member's inpatient claim received without a notification.	BlueCare – HMO myBlue – HMO SimplyBlue – HMO	Authorization required Hospice services require submission of the request and a treatment plan (hospice plan) by the member's PCP or participating provider for review and approval by Florida Blue (Health Options, Inc.)
	BlueSelect	Notification required. Submit notifications electronically through Availity®
Hospice Prior approval is not required for pre-hospice enrollment benefits.	FEP Basic – PPC/PPO FEP Standard – PPC/PPO FEP Blue Focus – PPC/PPO	Approval is required for the following services: •Traditional home hospice care •Continuous home hospice care •Inpatient hospice care
	State Employee PPO NetworkBlue PPO	No authorization, certification or notification required.
Hyperbaric Oxygen Hyperbaric oxygen treatment (99183, A4575, C1300) requires authorization.	BlueCare – HMO myBlue – HMO SimplyBlue – HMO	Submit authorization requests electronically through Availity®
Infertility Treatment	BlueCare – HMO myBlue – HMO SimplyBlue – HMO	Authorization required when benefit coverage is available.

Service	Network – Product	Contractual Obligation
Submit authorization requests electronically through Availity®	BlueSelect BlueOptions – NetworkBlue	Authorization, certification, or notification is not required. However, Voluntary Predetermination for Select Services is available for select services where Florida Blue has a Medical Policy.
Injectable Medication Submit authorization requests electronically through Availity®	BlueCare – HMO myBlue – HMO SimplyBlue – HMO BlueSelect BlueOptions – NetworkBlue	Authorization required Refer to Medical Pharmacy list for the specific drugs that requires prior approval.
	BlueChoice – PPC/PPO Traditional – PPS/PHS	Certification required for acute care hospitals and psychiatric/substance abuse facilities, including a partial hospitalization program.
Inpatient – Acute and Long-Term Acute Care (LTAC) Submit authorization requests electronically through Availity® Newborn admissions require separate authorization from mother if either baby stays after mother is discharged, admission will be billed with DRG 789-793, or if mother is not insured through Florida Blue. Certification for unplanned admissions should occur within one business day of admission. Certification for planned admissions should occur five business days prior to date of service.	BlueCare – HMO myBlue – HMO SimplyBlue – HMO	Authorization required
	BlueOptions – NetworkBlue Skilled Nursing Facility (SNF) with access to select high-cost medication through BriovaRx Infusion Services 204, Inc. for members admitted for sub-acute care.	Participating inpatient acute care facilities are required to notify Florida Blue of member admissions to SNFs before close of business of the day following admission. Florida BlueCare Coordinators review the SNF admission, either onsite or telephonically, and collaborate with the facility staff to assist with identifying coverage options available for members through focused condition, discharge planning and ancillary services as needed.
	BlueChoice – PPC/PPO Traditional – PPS/PHS	Certification required for acute care hospitals and acute rehabilitation.
Inpatient – Acute and Long-Term Acute Care (LTAC) Submit authorization requests electronically through Availity® Newborn admissions require separate authorization from mother if either baby stays after mother is discharged, admission will be billed with DRG 789-793, or if mother is not insured through Florida Blue.	BlueSelect Notification of unplanned admissions should be received as soon as possible, but no later than the end of the next business day. For changes from outpatient to inpatient status, an inpatient notification must be made at the time the member is admitted. Planned services: Notifications should be submitted five working days prior to the date of service.	**Penalty:** If timely notification is not made by a facility or if no notification is made, a financial penalty may be imposed of 20 percent of the total claim for an episode of care that would have otherwise been due to the inpatient facility under the Agreement then in effect if provider notification had been provided (regardless of payment methodology defined within the provider Agreement) up to a maximum of $500, for each BlueSelect member's inpatient

Service	Network – Product	Contractual Obligation
		claim received without a notification.
Inpatient – Acute and Long-Term Acute Care (LTAC) Submit authorization requests electronically through Availity® Newborn admissions require separate authorization from mother if either baby stays after mother is discharged, admission will be billed with DRG 789-794, or if mother is not insured through Florida Blue.	FEP Basic – PPC/PPO FEP Standard – PPC/PPO FEP Blue Focus – PPC/PPO $500 penalty applies if precertification is not obtained *Except members using benefits under the Blue Distinction Centers for transplant benefit Acute inpatient rehabilitation and LTAC services require approval by contacting the FEP Care Coordination.	Pre-admission certification is required for acute care and psychiatric and substance abuse facilities. Submit certifications electronically through Availity® ***Exceptions are:*** • Maternity admissions for routine delivery (routine is within 48 hours vaginal delivery/96-hour cesarean • Admissions outside the U.S. and Puerto Rico • When other insurance, including Medicare A, is paying primary* • When Medicare A is primary and member is confined to VA hospital.
Inpatient – Acute and Long-Term Acute Care (LTAC) Submit authorization requests electronically through Availity® Newborn admissions require separate authorization from mother if either baby stays after mother is discharged, admission will be billed with DRG 789-793, or if mother is not insured through Florida Blue.	State Employee PPO – NetworkBlue PPO	Preadmission certification required for acute care, LTAC and psychiatric and substance hospitals. Penalty is 20 percent of the allowed amount, not to exceed $500. ***Exceptions are:*** • When Medicare A is primary Out of country hospitals
Laboratory In most instances, referral should be made to Quest Diagnostics or Dermpath Diagnostics. The preferred lab for anatomical pathology services in Florida is AmeriPath. Submit authorization requests electronically through Availity® In Office Laboratory List	BlueCare – HMO myBlue – HMO SimplyBlue – HMO BlueChoice – PPC/PPO BlueOptions – NetworkBlue BlueSelect State Employee PPO – NetworkBlue PPO Traditional – PPS/PHS *Quest Diagnostics is Florida Blue's preferred laboratory provider.*	Laboratory services are managed under exclusive arrangement with Quest Diagnostics. If unable to use Quest Diagnostics, then a prior authorization is required. Services obtained at facilities other than Quest Diagnostics, Dermpath Diagnostics or AmeriPath may result in higher out-of-pocket cost for the member.
Licensed Midwife	BlueCare – HMO myBlue – HMO SimplyBlue - HMO	Submit authorization requests electronically through Availity®

Service	Network – Product	Contractual Obligation
Office and Outpatient Diagnostic Tests Submit authorization requests electronically through Availity® *See (Appendix J) for list of procedures or more detailed clinical guidelines.*	BlueCare – HMO myBlue – HMO SimplyBlue - HMO	Authorization required if done in outpatient setting. **Exception:** Participating physicians have standing authorizations for approval of certain diagnostic tests. Please see the Standing Authorization section of this manual.
Ophthalmology South Florida	BlueCare - HMO myBlue – HMO SimplyBlue - HMO	Ophthalmology for South Florida (Broward, Martin, Miami-Dade, Okeechobee, Palm Beach and St. Lucie counties) Physicians should coordinate services with EMI.
Oral Maxillofacial Submit authorization requests electronically through Availity®	BlueCare – HMO myBlue – HMO SimplyBlue - HMO FEP Basic - PPC/PPO FEP Standard - PPC/PPO FEP Blue Focus – PPC/PPO	Authorization required **Prior approval is required for:** •Outpatient surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof, and floor of mouth •Surgical correction of congenital anomalies
Orthotic / Prosthetic Authorization is required for all DME and Orthotic/Prosthetic needs provided by providers participating in the CareCentrix network.	All products Submit authorization requests electronically through Availity® CareCentrix at 877-561-9910, by fax at 877-627-6688, or online through the CareCentrix web portal.	**Providers that do not participate in CareCentrix network** may not require prior authorization but are eligible for a Voluntary Predetermination for Select Services for a covered service determination for equipment and supplies.
Outpatient Rehabilitation	BlueCare - HMO myBlue – HMO SimplyBlue - HMO	No authorization required
Outpatient Hospital Services (Includes 23 Hour Observation Care) Submit authorization requests electronically through Availity®	**BlueCare - HMO** All outpatient psychiatric and substance abuse admissions must be coordinated through Lucet Behavioral Health. **Note:** Labor check billed under revenue codes 720, 721 and 729 do not require authorization.	Authorization required All outpatient psychiatric and substance abuse admissions must be coordinated through Lucet Behavioral Health. **Note:** Labor check billed under revenue codes 720, 721 and 729 do not require authorization.
	BlueChoice - PPC/PPO BlueOptions - NetworkBlue Traditional - PPS/PHS	Notification is required for observation status admissions and all status changes from observation to inpatient. Other outpatient services do not require authorization or notification.

Service	Network – Product	Contractual Obligation
		Access Availity® for services and network information.
Pain Management Submit authorization requests electronically through Availity®	BlueCare – HMO myBlue – HMO SimplyBlue - HMO	Authorization required
Pharmacy - Provider Administered Drug Program applies (PADP) Magellan RX Management Self-administered drugs may not be covered in the office except those used in the treatment of diabetes, cancer, conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis which are covered. Hemophilia program – managed by Caremark	BlueCare - HMO myBlue – HMO SimplyBlue - HMO BlueSelect BlueChoice - PPC/PPO BlueOptions – NetworkBlue	Benefits vary by member contract and may contain medical cost share. Refer to PADP Medication List to determine drugs that require prior authorization Voluntary Predetermination for Select Services is available
	FEP Basic - PPC/PPO FEP Standard - PPC/PPO	Prior approval required for certain medications. Refer to Caremark for a current Rx drug prior approval list.
	State Employee PPO – NetworkBlue PPO	PADP applies Managed by OptumRx
Radiation & Oncology (continued on next page)	Large Group (Non-grandfathered): BlueOptions – NetworkBlue BlueCare – HMO BlueChoice – PPC/PPO Small Group BlueOptions – NetworkBlue BlueCare – HMO SimplyBlue BlueSelect Individual BlueOptions – NetworkBlue BlueCare – HMO myBlue - HMO BlueSelect	Any radiation oncology services provided to members enrolled in the following plans do not require prior authorization. This includes both the professional and institutional components of such services.

Service	Network – Product	Contractual Obligation
Radiation & Oncology	FEP	**FEP Members are managed by Florida Blue** Prior approval is required for all outpatient intensity-modulated radiation therapy (IMRT) except when related to the treatment of head, neck, breast, anal cancer, or prostate cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required for IMRT treatment of brain cancer.
Sleep Study - Please contact Care Centrix Sleep Management Program at (855) 243-3326 See (Appendix C) for list of procedures. BlueCare HMO plans do not require referrals when seeing participating specialists	BlueCare - HMO myBlue – HMO SimplyBlue - HMO BlueSelect BlueChoice - PPC/PPO BlueOptions – NetworkBlue Self-Funded groups are excluded from this delegated vendor Program	Florida Blue has implemented a mandatory pre-service review/prior authorization program for sleep and titration studies. For a list of group #'s exempt from Sleep Management Solutions please click here. CareCentrix Sleep Study Prior Auth Fax Request Form
Spine Care Spine Care procedures: See (Appendix E) for list of procedures.	BlueCare - HMO myBlue – HMO SimplyBlue - HMO BlueSelect BlueChoice - PPC/PPO BlueOptions – NetworkBlue Preferred Patient Care Traditional – PPS/PHS	Authorizations are required and should be requested via Availity®. Cosmetic, plastic, or reconstructive surgery is subject to medical necessity review.
Skilled Nursing Facility Select Medication Program The voluntary Select Medication Program is available to participating SNFs with access to select high-cost medication through BriovaRx Infusion Services 240, Inc. for members admitted for sub-acute care. See the SNF program for specific details. Contact our UM department at 1-877-205-2583	BlueCare - HMO myBlue – HMO SimplyBlue - HMO BlueSelect **BlueSelect Penalty:** If timely notification is not made by a facility of an inpatient admission or if no notification is made, a financial penalty may be imposed of 20 percent of the total claim for an episode of care that would have otherwise been due to the inpatient facility under the Agreement then in effect if provider notification had	Authorization required. Submit authorization requests electronically through Availity® (continued on next page)

Service	Network – Product	Contractual Obligation
	been provided (regardless of payment methodology defined within the provider Agreement) up to a maximum of $500, for each BlueSelect member's inpatient claim received without a notification.	
	BlueChoice - PPC/PPO Traditional - PPS/PHS	Notification of an admission is not required.
	BlueOptions – NetworkBlue	Participating facilities are required to notify Florida Blue of member admissions to SNFs before close of business of the day following admission.
Surgical Procedures (continued next page)	BlueCare - HMO myBlue – HMO SimplyBlue - HMO	Authorization required
	FEP Basic-FEP Standard FEP Blue Focus	Prior approval must be obtained for the following surgical services if performed in an outpatient setting: • Surgery for morbid obesity • Surgical correction of congenital anomalies • Surgery to correct accidental injuries to jaw, cheek, lips, tongue, roof, and floor of mouth Advanced Benefit Determination is available for select services; see our Voluntary Predetermination for Select Services in the Utilization Management section. The provider should fax their request and all necessary medical and member information (i.e., procedure, diagnosis codes, supporting documentation) to 1-866-441-1569. If the provider submits their request to FEP via mail, once received, our Customer Service Department will forward it to the appropriate location to be reviewed.
	BlueChoice – PPC/PPO BlueOptions - NetworkBlue State Employee NetworkBlue PPO Traditional	Authorization, certification, or notification is not required. However, Voluntary Predetermination for Select Services may be required. (continued on next page)

Service	Network – Product	Contractual Obligation
Therapy Physical/Occupational/Speech Language Pathologists ***Autism Spectrum Disorder Services** provided to a Covered Dependent consisting of: 1. Well-baby and well-child screening for the presence of Autism Spectrum Disorder; 2. Applied Behavior Analysis, when rendered by an individual certified per Section 393.17 of the Florida Statutes; and 3. Applied Behavioral Analysis (ABA is covered without limits and authorizations are coordinated under the Mental and Nervous by Lucet Behavioral Health) 4. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Autism Spectrum Disorder are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.	***Some*** BlueCare – HMO plans (see Contractual Obligation section) **Autism Spectrum Disorder** Group BlueCare, Group BlueOptions, and Group BlueChoice require authorization for therapy related Autism.	Some BlueCare plans DO require authorization for outpatient therapies: **Large Group** – Plans *REQUIRING* auth: 1, 2, 4, 6, 8, 12, 14, 15, 16, 20, 21, 40, 41 and 115. **Small Group** – plans *REQUIRING* auth: 2, 6, 8, 9, 12, 15, 21, 22, 23, 24, 25, 26, 30, 34, 35, 36, 40, 41, 42, 44 and 209. **Note:** Large group only- Therapy for Autism and Down Syndrome must continue to be covered even after outpatient therapy limits are met. **Individual Under 65 and Small Group only –** Outpatient habilitative physical therapy, occupational therapy, and speech therapy for Autism and Down Syndrome will continue to be covered even after outpatient therapy limits are met.
Transplant Services (continued on next page)	BlueCare – HMO myBlue – HMO SimplyBlue - HMO BlueChoice – PPC/PPO BlueOptions - NetworkBlue Traditional PPS/PHS BlueSelect - EPO	Authorization required for all transplant surgical procedures Transplant services may be subject to conditions and/or limitations of the member's contract. To determine whether a proposed transplant may be covered, the physician should contact our Utilization Management department. **HMO Products:** All transplant services (pre-transplant evaluation, transplant, and post-transplant care) require prior authorization.

Service	Network – Product	Contractual Obligation
		EPO/PPO Products: Effective March 1, 2021, prior authorization will be required for pre-transplant evaluation for EPO/PPO members seeking adult heart, liver, and kidney transplants. • ASO and BlueCard are excluded from this pre-transplant evaluation authorization requirement.
	FEP Basic/Standard/ Blue Focus (excluding office visits)	Prior approval required; contact our UM department and follow the appropriate prompts. Note: Prior approval is not required for kidney transplants or corneal tissue transplants.
	State Employee PPO (excluding office visits)	Prior Benefit determination must be obtained for all transplants except Kidney or Cornea. Contact our Utilization Management department to determine if benefit applies.
Urgent Care	BlueCare – HMO myBlue – HMO SimplyBlue - HMO BlueChoice – PPC/PPO BlueOptions - NetworkBlue Traditional PPS/PHS	No authorization required.

Provider Protocol Exemption Request

To prescribe a medication, medical procedure or course of treatment for a condition that is different from the step-therapy protocol developed by Florida Blue, complete the Provider Protocol Exemption Request Form. Additional information can be found in the Provider Protocol Exemption Instruction.

Medicare Utilization Management

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

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

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

Per your agreement with us, you are required to fully comply with all medical management programs.

This includes:

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

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

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

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

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

Coverage Determinations for BlueMedicare Members

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

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

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

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

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

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

- The CMS Medicare Coverage Database for information about NCD and LCD guidelines applicable to services rendered in Florida. These guidelines can be found at www.cms.gov.
- First Coast Service Options - Medicare LCD at http:\\medicare.fcso.com for information about LCD guidelines.
- For Florida Blue evidence-based Medical Policies use our Medical Coverage Guidelines on our Florida Blue website.

As with Physicians and other providers are responsible for understanding whether specific items and services are covered under Original Medicare and, therefore, also covered by our Medicare Advantage plans. A member's eligibility and benefits may be verified electronically through Availity®.com. If there is uncertainty regarding whether a service requested by a member is covered under Medicare, the provider or the member may request a pre-service Organization Determination from the plan; this also applies to referrals to other participating and non-participating providers.

If the pre-service Organization Determination is **denied** and the provider still renders the service, the claim must be billed using a -GA modifier (indicating a waiver of liability statement, known as an Integrated Denial Notice (IDN) for Medicare Advantage plans, was issued by the provider in advance, as required by plan

guidelines). The -GA modifier may only be billed if both an adverse Organization Determination was received and the member's signature is on file in the provider's record, indicating that the member was advised in advance of the service and clearly understands that it is not covered by Florida Blue and that he/she has agreed to be responsible for the cost of the service. If the provider did not obtain the IDN in advance of providing a non-covered service, then the member may not be billed for that service.

If a provider inappropriately refers a member for services to a participating or non-participating provider, we may not pay for the referral outside of payment agreements, and the provider who referred would be responsible for the payment and is not allowed to bill the patient, except for the applicable cost-sharing for that service as set forth in the member's EOC.

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

Utilization Management Table by Medicare Product & Network

Submit authorization requests electronically through Availity®

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

Service	Network – Product	Contractual Obligation
Cardiology Services (Non-Emergent)	Medicare Advantage HMO Medicare Advantage PPO	Non-Emergent Cardiology Services are subject to a prior authorization requirement. *This includes both the professional and institutional components of such services. Failure to obtain an authorization prior to rendering the services may result in a denial of the claim. Utilization Review for cardiology services is performed by New Century Health. (NCH) **Refer to:** NCH Cardiovascular UM List Access New Century Health at my.newcenturyhealth.com or via phone at 1-888-854-2098 (Monday – Saturday 8 a.m. – 8 pm. ET); option 1.
Chemotherapy Notification of a referral from a Primary Care Physician is required for ALL BlueMedicare HMO products when the member requires treatment from specialists, urgent and emergency care does not require a referral.	Medicare Advantage HMO	Referral required for all hematology/oncology office visits. Authorization in addition to the referral is required for select Chemotherapy drugs. Refer to NCH Oncology and Hematology UM Drug List **Refer to New Century Health** for chemotherapy drug authorizations at my.newcenturyhealth.com or via phone at 1-888-999-7713 (Monday – Saturday 8 a.m. -8 p.m. ET) – Medical Oncology choose option 2
	Medicare Advantage PPO	Authorization required for any chemotherapy services. Refer to NCH Oncology and Hematology UM Drug List **Refer to New Century Health** for chemotherapy drug authorizations at my.newcenturyhealth.com or via phone at 1-888-999-7713 (Monday – Saturday 8 a.m. -8 p.m. ET) – Medical Oncology choose option 2
Chiropractic	Medicare Advantage HMO Medicare Advantage PPO	Authorization is not required.
Clinical Education	Medicare Advantage HMO Medicare Advantage PPO	Authorization is not required.

Service	Network – Product	Contractual Obligation
Dialysis	Medicare Advantage HMO Medicare Advantage PPO	Authorization is not required.
Durable Medical Equipment You should also refer to CMS Guidelines and to Florida Blue's Medical Policies (Medical Coverage Guidelines) for specific requests. DME or medical supplies that exceed the quantity limitations in the Medical Policies (Medial Coverage Guidelines) are subject to prior authorization.	Medicare Advantage HMO Medicare Advantage PPO DME or medical supply items should be accessed through CareCentrix. CareCentrix will arrange for services to be rendered by one of its participating providers or when appropriate, refer the member to the applicable Florida Blue HMO DME, or medical supply provider that can render the needed services.	Authorization required. Requests should be submitted five working days prior to the date needed or within 24 business hours of the physician's order. Payment will be denied if authorization is not obtained. If extenuating circumstances exist that delayed this process, the provider should advise Florida Blue. Authorization requests to CareCentrix 877- 561- 9910, by fax at 877- 627- 6688 online through the CareCentrix web portal at https://www.carecentrixportal.com
Home Health/Home Infusion Home Health, home infusion are managed under an exclusive arrangement with CareCentrix for Florida Blue HMO. CareCentrix will arrange for services to be rendered by one of its participating providers or when appropriate, refer the member to the applicable Florida Blue HMO home health provider that can render the needed services.	Medicare Advantage HMO Medicare Advantage PPO	Authorization required. An example of services that CareCentrix may refer to a provider includes but is not limited to continuous nursing care beyond four hours. Authorization requests to CareCentrix 877- 561- 9910, by fax at 877- 627- 6688 online through the CareCentrix web portal at https://www.carecentrixportal.com

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

Service	Network – Product	Contractual Obligation
Inpatient - Acute Submit authorization requests electronically through Availity®	Medicare Advantage HMO Medicare Advantage PPO	Authorization required. Certification is required for acute care hospitals. Certification should occur within one business day of admission. Certification for planned admissions should occur five business days prior to date of service.
Inpatient - Acute Rehabilitation and Long-Term Acute Care (LTAC)	Medicare Advantage HMO Medicare Advantage PPO	Prior authorization required. Authorization requests to CareCentrix 877- 561- 9910, by fax at 877- 627- 6688; online at https://www.carecentrixportal.com/ProviderPortal/homePage.do
Outpatient Diagnostic Tests Includes tests provided in the office. Medicare Advantage participating physicians have standing authorizations for approval of certain diagnostic tests. Click here to view a list of codes.	Medicare Advantage HMO	Prior authorization may be required for certain services. Referral from a Primary Care Physician may be required for treatment from specialists, with the exception of urgent and emergency care providers.
	Medicare Advantage PPO	Prior authorization may be required for certain services.
Ophthalmology South Florida Ophthalmology for South Florida (Broward, Martin, Miami-Dade, Okeechobee, Palm Beach and St. Lucie counties) – members and/or physicians should coordinate services with EMI.	Medicare Advantage HMO Medicare Advantage PPO	Routine eye exams, diabetic retinal exams and eyeglasses do not require a referral and are administered through ICARE.
Oral Maxillofacial	Medicare Advantage HMO Medicare Advantage PPO	Authorization required.
Outpatient Hospital Services (Including 23-hour Observation Care)	Medicare Advantage HMO Medicare Advantage PPO	Authorization required. All outpatient psychiatric and substance abuse admissions must be coordinated through Lucet Behavioral Health.
Outpatient Rehabilitation	Medicare Advantage HMO Medicare Advantage PPO	Authorization required. All outpatient psychiatric and substance abuse admissions must be coordinated through Lucet Behavioral Health.

Service	Network – Product	Contractual Obligation
Pain Management	Medicare Advantage HMO Medicare Advantage PPO	Authorization required.
Pain Management **Pharmacy –**	Medicare Advantage HMO Medicare Advantage PPO Benefits vary by member contract and may contain medical cost share. This information can be found in Availity®. Member medical cost share exists for covered Medicare B care drugs administered in the office, which is 20 percent coinsurance.	A Prior authorization may be required for certain services, please check eligibility and benefits through Availity®. Refer to Part B Drug List to determine drugs that require prior authorization through Florida Blue.
Pharmacy - Self-Administered	Medicare Advantage HMO Medicare Advantage PPO	Refer to the Medication Guide to determine drugs that require prior authorization. Hemophilia program – managed by Caremark. Refer to the Medication Guide for Medicare eligible drugs covered under this plan. Refer to the Medicare Pharmacy section for additional pharmacy program details. • Some self-administered drugs require prior authorization as identified in the Medication Guide. Review the Medication Guide for specifics. • Click here for information regarding the differences Part B and Part D.

Service	Network - Product	Contractual Obligation
Radiation & Oncology Therapy	Medicare Advantage HMO Medicare Advantage PPO	Any radiation oncology services (other than services rendered in the emergency room or an inpatient setting) provided to members enrolled in the following plans are subject to a prior authorization requirement. This includes both the professional and institutional components of such services. Failure to obtain an authorization prior to rendering the services may result in a denial of the claim. New Century Health Billable Radiation & Oncology Codes. Authorization in addition to the referral is required for select Radiation and Oncology drugs. Refer to NCH Radiation UM Code List. Utilization Review is performed by New Century Health and can be accessed through their web portal at my.newcenturyhealth.com or via phone at **1-888-999-7713** (Monday – Saturday 8 a.m. to 8 p.m. ET) - Medical Oncology choose option 2 - Radiation Oncology choose option 3
Radiology	Medicare Advantage HMO Medicare Advantage PPO	Authorization is required.
Skilled Nursing Facility The voluntary Select Medication Program is available to participating SNFs with access to select high-cost medication through BriovaRx Infusion Services 204, Inc. for members admitted for sub-acute care.	Medicare Advantage HMO Medicare Advantage PPO	Authorization is required. Authorization requests to CareCentrix 877-561-9910, by fax at 877-627-6688, online through the CareCentrix web portal at https://www.carecentrixportal.com
Sleep Study Please contact Care Centrix Sleep Management Program at (855) 243-3326 See (Appendix C) for list of procedures.	Medicare Advantage HMO Medicare Advantage PPO	Florida Blue Medicare has implemented a mandatory pre-service review/prior authorization program for sleep and titration studies. For a list of group #'s exempt from Sleep Management Solutions please click here. CareCentrix Sleep Study Prior Auth Fax Request Form

Service	Network - Product	Contractual Obligation
Spine Care Spine Care procedures: Authorizations will be handled by Florida Blue Medicare.	Medicare Advantage HMO Medicare Advantage PPO	Authorizations will be handled by Florida Blue Medicare. See (Appendix H) for a list of procedures that are subject to medical necessity review. Link to Request Authorizations through Availity®.
Surgical Procedures	Medicare Advantage HMO Medicare Advantage PPO	Authorization required.
Therapy Physical Therapy Occupational Therapy Speech Language Pathology	Medicare Advantage HMO Medicare Advantage PPO	Authorization is required for physical/occupational therapy.
Transplant Services The facility performing the services must meet specific CMS criteria.	Medicare Advantage HMO Medicare Advantage PPO	Authorization required.
Transportation Non-Emergency This benefit provides non-emergency transportation for routine medical/dental appointments, to the pharmacy, for ongoing care arrangements, and to Florida Blue Centers with a clinician in select counties.	Medicare Advantage HMO This benefit is available in select counties.	Authorization is not required. Benefit includes 48 trips per calendar year. A trip is counted as one way; a round trip counts as two trips. Members must call LogistiCare at 1-855-875-519 to make a reservation.

Medical and Specialty Pharmacy Utilization Management

Select prescription drugs (including injectable medications) may require that specific clinical criteria are met before the drugs will be covered under Florida Blue's pharmacy and/or medical benefit programs. Outlined below is our UM programs and their applicable products.

Note: Always verify member's benefit as some utilize an Exclusive Provider Organization (EPO) for pharmacy benefits and the pharmacy must be a participating pharmacy in order to receive coverage.

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

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

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

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

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

Additions to this list will be made periodically in accordance with applicable provisions of your contract(s). Additionally, certain member benefit agreements may require prior authorization for certain drugs.

Note: The program is not applicable for drugs administered in an emergency room, observation unit or during an inpatient stay. Additionally, this program is not applicable for drugs ordered through Florida Blue Specialty Pharmacy Program (i.e. 'Just in Time', 'Drug Replacement'). As with all utilization management programs, PADP will be utilized to determine if the proposed service meets the definition of medical necessity under the member's benefit plan. Details of this pre-service review process are listed below. Requirements for the pre-service review process are applicable to the following products:

- HMO (BlueCare HMO, SimplyBlue, myBlue, BlueMedicare HMO)
- PPO (BlueChoice, BlueMedicare PPO, BlueOptions, BlueSelect)
- State Employees' PPO Plan
- Traditional

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

Procedures for Ordering Physicians

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

Magellan Rx Management Access Information

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

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

Website Access

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

Magellan Rx Management Request Timeframes

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

Claim Submission Information

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

Drug Units

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

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

Diagnosis

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

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

Modifiers

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

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

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

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

Specialty Pharmacy Medications-Self and Physician Administered

Select prescription drugs (including injectable medications) may require that specific clinical criteria are met before the drugs will be covered under Florida Blue's pharmacy and/or medical benefit programs. Outlined below are Florida Blue's UM programs and their applicable products.

Note: Always verify member's benefit as some utilize an exclusive provider organization (EPO) for pharmacy benefits and the pharmacy must be a participating pharmacy in order to receive coverage.

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

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

Program Description	Document Links
A list of commonly prescribed drugs where a member may discuss with their physician the opportunity to switch to a less costly generic alternative. Florida Blue will waive the initial co-pay when a member switches to a generic alternative. This link provides a list of the medications covered under the program. This program may not apply to all Florida Blue Pharmacy products.	
Pharmacy Benefit Programs	
Medications Not Covered List	Drugs that are Not Covered List
The pharmacy benefit may not cover select medications. Some of the reasons a medication may not be covered are:	
•The medication has been shown to have excessive adverse effects and/or safer alternatives	
•The medication has a preferred formulary alternative or over the counter (OTC) alternative	
•The medication is no longer marketed	
•The medication has a widely available/distributed AB rated generic equivalent formulation	
•The medication has been repackaged - a pharmaceutical product that is removed from the original manufacturer container (Brand Originator) and repackaged by another manufacturer with a different NDC.	

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

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

Pharmacy Utilization Management Guidelines

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

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

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

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

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

Voluntary Predetermination for Select Services (VPSS) Guidelines

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

- A pre-service medical necessity review will not be conducted for the following reasons:
    - If there is no current medical policy published for the requested procedure/services at the time of the request. To determine if there is an applicable medical policy, refer to the Medical Coverage Guidelines (MCGs) on our website at FloridaBlue.com.
    - Non-covered services per the member's benefit plan (check Availity® for Member benefits)
    - To determine billing edits and/or inclusive or bundled services.
    - Secondary or Medicare Supplement members
- For Federal Employee Program (FEP), State Group and Medicare Advantage products, Florida Blue will continue to conduct a pre-service medical review regardless of the reasons stated above. Pre-service medical necessity reviews for these members are determined at the time services are rendered according to the terms of the member contract.

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

- Members will have appeal rights in the event of a pre-service adverse benefit determination:
    - A member, or provider on behalf of a member, has the right to a pre-service appeal. To submit an appeal on a member's behalf, complete the HMO Member Grievance and Appeal Form or the Non-HMO Member Grievance and Appeal Form and obtain written permission from the member by completing the Member Appeals Appointment of

Representative Form. You will then submit the forms to Florida Blue. These forms are located on the member website at www.FloridaBlue.com.

The member is financially responsible for any rendered service deemed not medically necessary as a result of the VPSS review process.

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

How To

Please fax your request for voluntary review. On your cover sheet, please indicate that you are requesting a voluntary review. Please include supporting documents or a Certificate of Medical Necessity. Include your contact information in case the reviewer needs additional information.

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

Plan Type	Note on Cover Sheet	Fax Number
Federal Employee Program (FEP)	Advanced Benefit Determination	(866) 441-1569
State Employees' PPO Plan	Requesting VPSS	(877) 219-9448
Medicare Advantage (Blue Medicare) PPO	Requesting Organizational Determination	(904) 301-1614
For all other Lines of Business such as BlueOptions (NetworkBlue), Blue Select or BlueChoice (Preferred Patient Care) Exceptions: FEP, State Group, Medicare Advantage (Blue Medicare) HMO or PPO	Requesting VPSS	(877) 219-9448

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

Standing Authorization

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

Per your agreement with us, you are required to comply fully with medical management programs administered. Failure to obtain a prior authorization for the procedures listed in the appendices will result in the member and/or provider being held financially responsible for the procedure. There are however certain services that when performed in an office setting may not require a provider to obtain an authorization.

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

Authorization Guidelines

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

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

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

Referral Guidelines

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

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

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

Diagnostic Tests

Participating providers have standing authorizations for approval of the diagnostic tests below when performed in an in-network office or outpatient facility, including a free-standing location of service. This list contains commonly billed tests and is not all-inclusive.

Note: When a diagnostic test is performed as part of a treatment/service that requires an authorization, an authorization for the main service needs to be obtained. If not authorized, the entire claim may be denied.

The Diagnostic Tests listed in the following section when performed in an office setting *may* not require an authorization for services and does not constitute payment; claims will process according to the coverage terms, limitations, and exclusions of the member's benefit plan at the time services are rendered. The final determination of whether or not a procedure is covered will depend on the actual claim(s) submitted. (Please note description, exception, and special instruction as some members, plans and/or products may require authorization.)

Note: Always refer to the current CPT coding manuals and guidelines for full description of all codes.

Note for Medicare: For *Cardiovascular and Cardiovascular Diagnostic Imaging (Aorta and Arteries),* please refer to the NCH Cardiovascular UM Code List for services that require authorization in all settings.

Diagnostic Tests

Diagnostic Tests	
Codes	**Description, Exception and/or Special Instruction**
Allergy	
95004	
95017 - 95071	
Cardiokymography	
Q0035	
Cardiovascular	
92978	Endoluminal Intravascular Ultrasound OCT C 1st
92979	Endoluminal Intravascular Ultrasound OCT C Each
93000 - 93024	
93224 - 93227	
93268 - 93272	
93303 - 93304	Transthoracic Echocardiograph (TTE)
93306 - 93308	TTE w/Doppler Complete; TTE w/o Doppler Complete; TTE Follow-up or Limited
93312 - 93317	Echo, Transesophageal
93320 - 93321	Doppler Echo Exam, Heart
93325	Doppler Color Flow, Add-on
93350 - 93352	Echocardiography
93354 - 93464	Coronary Angiography
93561 - 93568	
93569 - 93572	
93600 - 93642	
93662	Intracardiac ECG (ICE)
93724	Analyze Pacemaker System
93770	Measure Venous Pressure
93978 - 93979	Vascular Study
93880	Extracranial Study, Complete, Bilateral
93882	Extracranial Study, Unilateral or Limited

Diagnostic Tests	
Codes	**Codes**
93922 - 93926	Lower Extremity Study
93930 - 93931	Upper Extremity Study
Gastroenterology	
43200	
91010 - 91013	
91037 - 91065	
91122	
Male Genital System	
54240	
54250	
Maternity	
59020	
59025	
Mobil Imaging	
Q0092	Portable X Ray
R0070 – R0076	Transport of Portable X Ray
Neurology and Neuromuscular	
95816	
95819	
95829	
95860 – 95875	
95907- 95913	
95921- 95937	
95954- 95962	
Non-Invasive Vascular	
93886 – 93895	
93950 – 93977	
93990	
Ophthalmology	
92060	
92081- 92083	
92136	
92235 – 92250	
Otorhinolaryngology	
92540 - 92546	
92562	
92564 - 92588	
92612 – 92617	
Pulmonary	
94010	
94772	
94060 - 94621	
94680 - 94750	
94770	
Radiological Guidance	
77011 – 77014	Computed Tomography
77021 & 77022	Magnetic Resonance
77065 - 77067	Breast Mammography
77071-77077 & 77080	Bone/Joint Studies

Diagnostic Tests	
Codes	**Description, Exception and/or Special Instruction**
19081, 19281 & 19283	Other
Radiology Diagnostic Imaging	
70010 – 70332,70350 -	Head and Neck
71010 – 71130	Chest
72020-72120, 72170, 72190,72200-72270 and 72285 - 72295	Spine and Pelvis
73000 - 73140	Upper Extremities
73501- 73660	Lower Extremities
74000 – 74022, 74190	Abdomen
74210 – 74363	Gastrointestinal Tract
74400 – 74485	Urinary Tract
74710, 74740, 74775	Gynecological and Obstetrical
75600-75630, 75705- 75774, 36223- 36227, 36251-36254, 36901 – 36906, 93556	Aorta and Arteries
75801 – 75893	Veins and Lymphatics
75894-75989, 34701 – 34711,0254T	Transcatheter Procedures
0234T–0238T	Transluminal Atherectomy
37225 – 37229, 37231- 37235	Endovascular Revascularization with or without stent *Auth required for BlueMedicare℠ Medicare Advantage members*
76000 - 76140	Other
Radiology Nuclear Medicine	
78012-78075	Endocrine
78102-78195	Hematopoietic, etc.
78201-78291	Gastrointestinal
78300-78320, 78350, 78351	Musculoskeletal
78414-78445, 78456-78458	Cardiovascular
78579-78598	Respiratory
78600-78607, 78610-78645, 78650, 78660	Nervous
78700-78761	Genitourinary
78800-78807	Other
Radiology Ultrasound	
76700-76776	Abdomen and Retroperitoneum
76641-76642	Breast
76818-76872	Pelvis – OB, Non-OB, Genitalia
76881-76886	Extremities
76930-76964	Guidance Procedures
76970-76998	Other Procedures
76506-76513, 76516-76536	Head and Neck
76604, 76641, 77065-77067, 51725-51798	Chest

Radiation Oncology Treatments

Participating providers have standing authorizations for approval of radiation oncology treatments below when performed in a physician office, hospital outpatient or ambulatory surgical center's location of service. This list contains commonly billed treatments and is not all-inclusive.

Note: When a treatment is performed as part of a treatment/service that requires an authorization, an authorization for the main service needs to be obtained. If not authorized, the entire claim may be denied.

The Radiation Oncology treatments listed in the following section when performed in an office setting may not require an authorization for services and does not constitute payment; claims will process according to the coverage terms, limitations, and exclusions of the member's benefit plan at the time services are rendered. The final determination of whether or not a procedure is covered will depend on the actual claim(s) submitted. (Please note description, exception and special instruction as some members, plans and/or products may require authorization.)

Note: Always refer to the current CPT coding manuals and guidelines for full description of all codes.

Note for Medicare: This table does not apply to Medicare. Please refer to the NCH Radiation Oncology UM Code List.

Radiation Oncology	
Codes	**Description, Exception and/or Special Instruction**
19296 - 19298	Placement of Radiotherapy
20555	Placement of Needles or Cath
31643	Bronchoscopy, Rigid or Flexible
41019	Placement of Needles, Catheters
43499	Esophagus Surgery Procedure
47999	Bile Tract Surgery Procedure
55860 (55862, 55865, 55875, 76873, G0458)	Surgical Exposure, Prostate
55899	Genital Surgery Procedure
55920	Placement of Needles or Catheter
57155 - 57156, 58346	Insertion of Radiation Source for Clinical Brachytherapy
61796 - 61799	Stereotactic Radiosurgery; Cranial
61800	Application of Stereotactic Radiosurgery; Cranial
63620 - 63621	Stereotactic Radiosurgery (Spinal) Procedures on the Spine and Spinal Cord
67218	Destruction of Localized Retinal Lesion
77261 - 77263	Clinical Radiation Treatment Planning
77280	Clinical Radiation Treatment Planning; Set Radiation Therapy Field; Single Area
77290	Clinical Radiation Treatment Planning; Set Radiation Therapy Field; Complex, 3 or more areas
77300	Basic Radiation Dosimetry Calculation
77301	Intensity Modulated Radiotherapy (IMRT)
77307	Teletherapy Isodose Plan
77316 - 77318	Brachytherapy Isodose Plan
77332	Radiation Treatment Simple Devices and Special Services
77334	Radiation Treatment Complex Devices and Special Services
77336	Continuing Medical Radiation Physics Consultation
77338	Multi-Leaf Collimator (MLC)
77370	Special Medical Radiation Physics Consultation

Radiation Oncology	
Codes	**Description, Exception and/or Special Instruction**
77371 - 77373 (G0339-G0340)	Radiation Treatment Delivery
77385 - 77386 (G6015 - G6016)	Intensity Modulated Radiation
77387 (G6001 - G6002, G6017, 77014)	Guidance for Localization of Target Volume
77402 (G6003 - G6014, 77407, 77412, 77295)	Radiation Treatment Delivery
77417	Radiology Port Image(s)
77427	Radiation Treatment Management (5 Treatments)
77432	Stereotactic Radiation Treatment
77435 (32701)	Stereotactic Body Radiation
77470	Special Radiation Treatment
77520 (77522-77523, 77525)	Proton Treatment, Simple, Without Complications
77761 (77762-77763, 76965, 77767-77768, 77771-77772, 77778, 77785-77787	Intracavity Radiation Source Application, Simple
77790	Supervision, Handling, Loading of Radiation Element
S8030	Scleral Application of Tantalum Ring(s)
C1717	Brachytherapy Source, Non-Standard, High Dose Rate Iridium – 192 Per Source
Q9958	High Osmolar Contrast Material, ≤ 149 mg/ml Iodine Concentration, per 1 ml

Durable Medical Equipment and Orthotic/Prosthetic

Details for NetworkBlue

Authorization is required for all DME and Orthotic/Prosthetic needs provided by providers participating in the CareCentrix network. All authorizations are to be requested through CareCentrix, Florida Blue's statewide provider for these services.

Physician/Provider offices that have historically supplied and billed for equipment/supplies from their offices, as a result of patient treatment, can continue to do so and do not need to work through CareCentrix; these items may or may not require authorization.

For physician/provider offices or any DME and Orthotics/Prosthetic provider that does not participate in CareCentrix network, the Florida Blue website contains Medical Policies (Medical Coverage Guidelines) showing requirements for specific DME an Orthotics/Prosthetics. Please review the specific Medical Policies (Medical Coverage Guidelines) before providing equipment or a supply.

Note: If a provider participating in the CareCentrix network does not submit the request or provides equipment CareCentrix does not authorize, the claim will be denied and the provider may not bill or collect payment from CareCentrix, Florida Blue, or the member.

For providers NOT participating in the CareCentrix network that require authorization for specific equipment, please contact Florida Blue directly.

Submit authorization requests electronically through Availity®.

Details for BlueSelect and Health Options

Requests for all DME, Medical Supplies, and Orthotics/Prosthetics must be coordinated statewide through CareCentrix for all Health Options (BlueCare, myBlue, SimplyBlue and BlueMedicare HMO) members.

BlueSelect members have no coverage for DME, MS, and O&P items supplied by a non-participating BlueSelect provider or a provider who is not an Exclusive Provider for non-emergency services. For approval of DME for our Blue Select product, medical supply (MS), and Orthotic/Prosthetic (O&P) items listed below when a participating BlueSelect provider supplies the items. If a non-participating BlueSelect provider or a provider who is not an Exclusive Provider is requested to supply DME for emergency services, then a BlueSelect authorization is required for claim payment.

Florida Blue will continue to monitor the usage of DME, MS, and O&P items, and will have the right to audit records pursuant to the provider's contract with BlueSelect.

For BlueSelect members, a physician will have a standing authorization for approval of DME, medical supply (MS), and Orthotic/Prosthetic (O&P) items listed below when a participating BlueSelect provider supplies the items.

Durable Medical Equipment Table

Items	Codes	
CPAP / BiPAP Accessories	S8186	
Infusion Pumps / Supplies	A4221 – A4223, A4230 – A4232, A4300 E0779, E0780	
Orthotics / Prostheses / Supplies	A4280 L0120 – L0160, L0172 – L0220, L0450 – L0454, L0466 – L0472, L0621, L0625 – L0628, L0630, L0633, L0970 – L0980, L0984, L1600 – L1620, L1650 – L1660, L1810, L1832, L1836, L1850, L1901, L1902, L1906, L1910, L1930, L1971, L2112 - L2116, L2132, L2180 – L2320, L2335, L2360 – L2385, L2390 – L2500, L2550 – L2624, L2630 – L2850	L3208 – L3211, L3260, L3650 – L3670, L3675 – L3710, L3760, L3762, L3807, L3908 – L3912, L3915, L3917, L3923 – L3931, L3956, L3960, L3962, L3980 – L3984, L3995, L4350 – L4398, L8000 – L8030, L8300 – L8330,
Slings / Traction	A4565	
Urinary Retention Supplies	A5200, E0275, E0276, E0325, E0326	
Miscellaneous	E1902	

Independent Clinical Laboratory

With the exception of the Preferred Patient Care (PPO) and Traditional/PPS networks, only the laboratory services listed below are eligible for payment when performed in the office by a participating BCBSF or Health Options physician. Any other laboratory services performed in the office will be denied for payment and the member may not be billed. Draw fees are only eligible for payment when lab services are sent to an outside laboratory.

Other laboratory services should be referred to a participating laboratory service provider for the member's plan. In most instances, referral should be to Quest Diagnostics and Dermpath Diagnostics. The preferred lab for anatomical pathology services in Florida is AmeriPath.

Codes	Descriptors
36415*	Collection of venous blood by venipuncture
80048	Basic metabolic panel
80051	Electrolyte panel (CO2, Cl, K, Na)
80076	Hepatic function panel (7)
81000	Urinalysis, by dip stick or tablet reagent, non-automated with microscopy
81001	Urinalysis, by dip stick or tablet reagent, automated with microscopy
81002	Urinalysis, by dip stick or tablet reagent, non-automated without microscopy
81003	Urinalysis, by dip stick or tablet reagent, automated without microscopy
81005	Urinalysis, qualitative or semi quantitative, except immunoassays
81015	Urinalysis; microscopic only
81025	Urine pregnancy test, by visual color comparison methods
82150	Amylase
82247	Bilirubin; total
82270	Consecutive collected specimens with single determination, for colorectal neoplasm screening
82272	1 to 3 simultaneous determinations, performed for other than colorectal neoplasm screening
82565	Creatinine; blood

In Office Laboratory List

Codes	Descriptors
82803	Gases, Blood, any combination of PH, PCO2, PO2, CO2, HCO3 (including calculated O2 saturation)
82946	Glucagon Tolerance Test
82947	Glucose; Quantitative, Blood (Except reagent strip)
82948	Glucose; blood, reagent strip
83036	Hemoglobin; Glycosylated (A1C)
83861	Microfluidic Analysis utilizing an integrated collection and analysis device, tear Osmolarity
84703	Gonadotropin, Chorionic (HCG); Qualitative
85013	Blood count; Spun Microhematocrit
85014	Blood count; hematocrit (HCT)
85018	Hemoglobin (Hgb)
85025	Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85060	Blood smear, peripheral, interpretation by physician with written report
85097	Bone marrow, smear interpretation
85610	Prothrombin time
86308	Heterophile antibodies; screening
86580	Skin test, Tuberculosis, intradermal
87210	Wet mount for infection agents (e.g., saline, India ink, KOH preps)
87220	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (e.g., scabies)
87400	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method; Influenza A or B, each

87420	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method; respiratory syncytial virus
Codes	**Descriptors**
87425	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method; rotavirus
87430	Infectious agent antigen detection by enzyme immunoassay technique, Streptococcus, group A
87631	Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (e.g., adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets
87804	Infectious agent detection by immunoassay with direct optical observation; influenza
87807	RSV assay w/ optic
87809	Infectious agent detection by immunoassay with direct optical observation; adenovirus
87880	Infectious agent detection by immunoassay with direct optical observation; Streptococcus, group A
88172	Cytopathology. Evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s).
88177	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis.
89051	Cell count, miscellaneous body fluids, except blood; with differential count
89060	Crystal identification by light microscopy with or without polarizing lens analysis, or body fluid (except urine)
89190	Nasal smear for eosinophils
89300	Semen analysis; presence and/or motility of sperm including Huhner test

Advanced Imaging

Commercial Plans

For BlueCare, *BlueChoice, BlueOptions, BlueSelect, myBlue, and SimplyBlue members, physicians should contact Florida Blue via Availity® to authorize or obtain a pre-service review for CT scans, CTAs, MRIs/MRAs, PET scans and nuclear medicine – cardiovascular system procedures (myocardial imaging, myocardial infusion studies and cardiac blood pool imaging advanced imaging services) when performed and billed in an outpatient or office location.

Certain contracts specifically exclude reimbursement for advanced imaging radiology services. The advanced imaging radiology service categories listed below are ineligible for payment in an office setting for these contracted providers.

- CT Scans
- MRIs/MRAs
- PET Scans
- Nuclear Medicine – Cardiovascular System Procedures (myocardial imagining, myocardial perfusion studies and cardiac blood pool imaging)

Providers, which include hospitals, IDTCs, and physicians, should verify an authorization or pre-service review has been obtained before performing these services.

See (Appendix J) for list of procedures or for more detailed clinical guidelines.

Medicare Plans

For BlueMedicare HMO and BlueMedicare PPO members, physicians should contact Florida Blue via Availity® to authorize or obtain a pre-service review for CT scans, CTAs, MRIs/MRAs, PET scans and nuclear medicine – cardiovascular system procedures (myocardial imaging, myocardial infusion studies and cardiac blood pool imaging advanced imaging services) when performed and billed in an outpatient or office location. Florida Blue review does not apply to services rendered in an Emergency Room, Observation Room, surgery center or hospital inpatient setting.

Certain contracts specifically exclude reimbursement for advanced imaging radiology services. The advanced imaging radiology service categories listed below are ineligible for payment in an office setting for these contracted providers.

- CT Scans
- MRIs/MRAs
- PET Scans
- Nuclear Medicine – Cardiovascular System Procedures (myocardial imagining, myocardial perfusion studies and cardiac blood pool imaging)

Providers, which include hospitals, IDTCs, and physicians, should verify an authorization or pre-service review has been obtained before performing these services. Authorizations will be handled by Florida Blue.

See (Appendix-B) for a detailed list of procedures and clinical guidelines.