



Manual for Physicians and Providers



Care Review

Coordination of Benefits

Appeals and Grievances

Quality, Compliance and Audit Programs

Self Service Tools and Resources

DOCUMENTATION OF CARE REVIEW	5
Guidelines for Primary Care Physician Medical Record Review.....	5
SUBROGATION AND COORDINATION OF BENEFITS	6
Coordination of Benefits with Medicare Group Plans.....	13
APPEALS – MEDICARE	16
PROVIDER APPEALS	18
General Appeal Guidelines	18
Administrative Appeals	18
Provider Clinical Appeals.....	19
Non-Clinical Appeals	20
Lucet Behavioral Health Appeals Contact Information:.....	20
Post-Service Appeals - Provider	20
Pre-Service Appeals – Member	21
Coding and Payment Rule Appeal	21
Utilization Management Appeals.....	22
MEMBER APPEALS	23
Member Commercial Plan Appeal Review Process	23
Florida Blue HMO Member Appeal General Rules	23
Florida Blue HMO Member Grievance and Appeals	24
Member Standard Appeals.....	25
Member Pre-Service Appeals	25
Member Medicare Appeals	26
MEDICARE ADVANTAGE APPEALS – NON-PAR PROVIDERS	27
Appeals for Medicare Advantage Non-Par Providers	27
MEMBER GRIEVANCE.....	29
COMPLIANCE & PROGRAMS	31
Quality Programs.....	31
Medicare Stars Program.....	31
Clinical Practice Guideline Monitoring and Improvement.....	33
Condition Specific Interventions and Programs	33
Financial Incentives Policy for Utilization Management Programs.....	33

Incident Reporting	34
Member and Provider Satisfaction Assessment	34
Comprehensive Quality & Risk Program (CQRP)	34
Preventive Health Monitoring and Improvement	35
Quality Performance Indicators	35
Under-Utilization and Over-Utilization Assessment	35
Quality Improvement Organization	36
Diagnostic Imaging Quality Program	37
Advanced Imaging Service (AIS) Providers Quality Program	37
Hospital Readmission Review Quality Program	38
Audit Programs	38
Participating Providers Responsibility	43
Member Rights and Responsibilities	45
SELF SERVICE	49
Electronic Self-service tools	49
Administrative Solutions	51
Authorizations	51
Eligibility & Benefits Inquiry and Response	52
Eligibility & Benefits Patient Care & ICD-10 Coding Reminders	53
Eligibility & Benefits Inquiry Screen	53
New Claim Status Tool	54
Fast Path Priority Service process for NCS	55
Claim Status	56
Claim Reconciliation Tool	57
Clear Claim Connection	58
Care Read	59
Telephone Self-service tools	60
Telephone Self-Service Tips	60
Claims List –Self-Service Commands	60
Eligibility & Benefits List – Benefit Information	61
Eligibility & Benefits List by Service Type –Self –Service Commands:	61
Availity® Issues:	63
Other Resources	63
Frequently Used Telephone Numbers and Information:	64
Electronic Claim Submission	64
Electronic Submission of Corrected Claims	65
Professional Real-Time Claim Adjudication	66
RTCA Messages	66
CLINICAL SOLUTIONS	67

Authorization and Referrals Inquiry, Update and Voids	67
Inquiries	67
Referral Tool Enhancement for PCPs Choosing Specialists for Members	67
How to Demo the Referral Tool	67
Updates	68
eCensus Tool	68
ProviderVista	69
Electronic Appeal.....	69
Electronic Care Reminders	69
Clinical Quality Validation Forms.....	70
Patient Care Summary	70
FINANCIAL SOLUTIONS.....	71
Patient Cost Estimator.....	71
Other Blue Plans	72
Patient Cost Estimator Messages	72
Medical Services Requiring Authorization or Pre-Service Review.....	73
Professional Patient Cost Estimator Specifics	73
Electronic Funds Transfer	73
Electronic Remittance Advice.....	74
Remittance Viewer	75
MEMBER SOLUTIONS	75
Member Tools	76
Care Comparison	76
Care Comparison Exclusions:	77
HOW TO AVOID PROVIDER IDENTIFICATION ERRORS.....	80
Billing Provider Section.....	80
Rendering Provider Section.....	80
Billing as a Group Provider.....	81
Billing as an Individual Provider Option 2.....	82
Ancillary Billing with NPI	83
Florida Blue NPI Attribute Matrix and Legend	84
NPI Attributes Technical Information	85

Documentation of Care Review

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

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

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

Guidelines for Primary Care Physician Medical Record Review

- The medical record is legible.
- Each page of office progress notes contains member name and identification number such as Florida Blue member ID, date of birth or physician office medical record ID number.
- The provider is identified on each entry in the record with a legible signature or initials.
- The medical record contains biographical data including date of birth, name, member identification number, and gender.
- The record contains a problem list or a summary of significant problems, medical diagnoses, and/or conditions and operative/invasive procedures.
- Current medications are documented on a medication list or listed in progress notes.
- Allergies and adverse reactions to medications are documented. If there are none, then documentation should indicate NKA (no known allergies).
- There is documentation whether or not the member age 18 and older has executed an advance directive.
- The main complaint or reason for each office visit is clearly stated.
- All entries of the progress notes are dated.
- Unresolved problems from previous office visits are addressed in subsequent visits.
- For pediatric/adolescent members (ages 16 and under) there is a completed, up-to-date immunization record in the chart.
- The medical record contains a past medical history.
- For members age 12 and older there is documentation of inquiry/counseling regarding tobacco use.
- For members age 12 and older there is documentation of inquiry/counseling regarding history of alcohol/substance abuse.

- The medical record contains a complete physical examination.
- Objective findings are documented, including appropriate vital signs.
- Diagnosis is supported by subjective and objective findings.
- There is a documented treatment plan that is consistent with the diagnosis.
- Laboratory, X-ray, and diagnostic studies are present in the record and reflect primary care review (signed, stamped, typed or electronic).
- Consultations present in the record reflect primary care review (signed, stamped, typed or electronic).
- Follow-up plans documented at each visit in the medical record.
- There is evidence that appropriate preventive screenings and services are completed for children and adults in accordance with Health Options, Inc./Health Maintenance Organization's practice guidelines. Health Options, Inc./Health Maintenance Organization has adopted guidelines from the USPSTF's Guide to Clinical Preventive Services. Visit the Agency for Healthcare Research and Quality website for the latest age/gender specific clinical recommendations.

Subrogation and Coordination of Benefits

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

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

Coordination of Benefits (COB) — COB is administered according to the Customer's benefit plan and in accordance with applicable law. We accept secondary claims electronically. COB or Health Order Liability (HOROL) is the member's responsibility to provide other insurance information to us. Providers can access the [Other Insurance Form](#) and also request copies of our COB brochure.

Members who do not update other insurance information may have their claims denied and will be responsible for the charges. Providers may bill the member for services that were denied for lack of other insurance information.

Billing Primary and Secondary Insurance

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

Coordination of Benefits Rules

COB Rules May vary by contract (rules below do not cover every situation)	
Contract Holder/Spouse	<p>The plan without a COB provision pays before a plan with a COB provision.</p> <p>Note: In cases involving Medicare, primary/secondary status is subject to the Medicare secondary payer rules (see COB with Medicare), which further determine order of liability based on group size and Medicare eligibility reason.</p>
Active/Inactive Rule	<p>The benefits of a plan covering a person who is neither laid off nor retired pays before a plan that covers a person who is laid off, retired or inactive. This rule does not supersede the dependent rule.</p>
Dependent Children	<p>Submit to the parent's plan whose birth date, based on month and day, falls earliest in the year, disregarding the year of birth.</p> <p>For example: The mother's date of birth is April 1, 1950 and the father's is August 7, 1948. Submit to the mother's plan first.</p> <p>If the parents of the child are divorced or legally separated, submit first to the plan of the parent with financial responsibility for health care coverage per the court decree.</p> <p>If not stated in the decree, submit bills in the following order:</p> <ul style="list-style-type: none"> The plan of the parent with custody The plan of the spouse of the parent with custody The plan of the natural parent without custody The plan of the spouse of the parent without custody

Other Coordination of Benefit Information

Other COB Information	
Auto	<p>In general: No Fault Auto insurance provides coverage for losses sustained as a result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle. Payments for such claims are made by the carrier that provides coverage for the owner or driver of the vehicle in which the injured party was a passenger. Florida Blue would pay as primary until the PIP deductible has been satisfied. The auto carrier would then assume the responsibility of the primary payer up to policy limits.</p> <p>If the auto carrier denies payment due to exclusion under its contract:</p> <p>The notice of the rejected claim must be submitted with claims to Florida Blue.</p> <p>An injured party may elect to reserve PIP coverage for lost wages. Notice of the reservation must be submitted with claims to Florida Blue.</p> <p>A participating provider may not elect to withhold claims for members with Florida Blue insurance coverage in favor of collecting from settlement proceeds from an injury where there is third party liability. To do so constitutes balance billing and is a breach of contract for participating providers.</p>
Automobile Accident Claim Submission	<p>Submit the claim to auto insurance carrier unless the patient states they have no PIP coverage.</p> <p>Members without PIP coverage must write a statement to the provider's office indicating such.</p> <p>Note: PIP coverage is required in order to have a valid Florida Driver's license.</p> <p>The statement must be signed and dated by the member.</p> <p>Submit the claim to Florida Blue using the Health Insurance Claim Form (CMS-1500) and/or the UB-04 claim form.</p>

Other Coordination of Benefit Information Cont'd

Other COB Information	
<p>CMS-1500 Form Guidelines</p> <p>Note: Florida Blue's Other Party Liability department may contact the member or automobile insurance carrier for additional information.</p>	<p>Complete member information and all applicable fields:</p> <ul style="list-style-type: none"> • Enter "yes" in box 10-B • Enter the accident date in field 14 • Enter all diagnosis codes in section 21 • Attach the following to the claim: <ul style="list-style-type: none"> • Copy of the check • EOB • Provide a copy of the Exhaustion letter from primary insurance carrier • Statement from member indicating no PIP coverage • PIP worksheet (if available)
<p>UB-04 Form Guidelines</p> <p>Note: Florida Blue's Other Party Liability department may contact the member or automobile insurance carrier for additional information.</p>	<ul style="list-style-type: none"> • Enter the occurrence codes and accident date in fields 33-35 use code 01 or 02 • Enter the condition code in fields 18-28 use code 03 • Enter the value codes in field 39-41 use code 14 • Enter all diagnosis codes in fields 67-76 • Enter the E-diagnosis codes in field 77 • Attach the following to the claim: <ul style="list-style-type: none"> • Copy of the check • EOB • Provide a copy of the Exhaustion letter from primary insurance carrier • Statement from member indicating no PIP coverage • PIP worksheet (if available)

Other Coordination of Benefit Information Cont'd

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

Worker's Compensation

Other COB Information	
Workers' Compensation Claim Submission	<p>If the services are work related, submit the claim to the worker's compensation insurance carrier.</p> <p>After the worker's compensation insurance carrier has processed the claim, submit the claim to Florida Blue using the Health Insurance Claim Form (CMS-1500) and/or the UB-04 claim form.</p>
CMS-1500	<p>Complete member information and all applicable fields:</p> <ul style="list-style-type: none">• Enter "yes" in box 10-B• Enter the accident date in field 14• Enter all diagnosis codes in section 21• Attach the following to the claim:• Copy of the check• EOB• Provide a copy of the Exhaustion letter from primary insurance carrier• Statement from member indicating no PIP coverage• PIP worksheet (if available) <p>Note: Florida Blue's Other Party Liability department may contact the member or automobile insurance carrier for additional information.</p>

Facility of Payment

Whenever payments which should have been made by us are made by any other person, plan, or organization, we shall have the right, exercisable alone and in our sole discretion, to pay over to any such person, plan, or organization making such other payments, any amounts we shall determine to be required in order to satisfy our coverage obligations hereunder. Amounts so paid shall be deemed to be paid under this Contract and, to the extent of such payments, we shall be fully discharged from liability.

Non-Duplication of Government Programs

The benefits provided under this Contract shall not duplicate any benefits to which you are entitled, or for which you are eligible, under governmental programs such as Medicare, Veterans Administration, TRICARE, or Workers' Compensation, to the extent allowed by law or any extension of benefits of coverage under a prior plan or program which may be required by law.

Coordination of Benefits with Medicare Group Plans

Medicare is Primary

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

BlueMedicare

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

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

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

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

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

Medicare is not the Primary Payer

To ensure accurate payment and processing for Florida Blue and other Blue Plan primary claims, which includes MA plans, submit claims with the following information:

Coordination of Benefits (COB) Medicare products

The Following are examples of when group insurance would pay before Medicare

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

Other COB Information	
UB-04 Form Guidelines	<ul style="list-style-type: none"> • Enter the occurrence codes and accident date in fields 33-35 use code 01 or 02 • Enter the condition code in fields 18-28 use code 03 • Enter the value codes in field 39-41 use code 14 • Enter all diagnosis codes in fields 67-76 • Enter the E-diagnosis codes in field 77 • Attach the following to the claim: • Copy of the check • EOB • Provide a copy of the Exhaustion letter from primary insurance carrier • Statement from member indicating no PIP coverage • PIP worksheet (if available) <p>Note: Florida Blue's Other Party Liability department may contact the member or automobile insurance carrier for additional information.</p>

When submitting a paper corrected claim, follow these steps:

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

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

Appeals – Medicare

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

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

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

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

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

Reconsideration is the First Step in the Appeal Process

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

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

Standard Reconsideration Requests

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

1. For Services:

Original adverse organization determination overturned:

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

Original adverse organization determination upheld:

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

2. For Payment:

Original adverse organization determination overturned:

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

Original adverse organization determination upheld:

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

Provider Appeals

Providers may request reconsideration of how a claim processed, paid or denied. These requests are referred to as appeals. Florida Blue will conduct a one-time appeal review, however, there is no second level appeal rights for a post-service provider appeal. Not all claim denials are eligible for a provider appeal. For example, services are not eligible for a provider appeal include but are not limited to:

- Office and outpatient evaluation and management codes for place of service 19 or 22
- Drug Screens

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

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

Appeal Appropriateness

Providers may submit an appeal if there is financial liability for the provider or the provider is sending the appeal on behalf of the member. Please refer to [‘Member Commercial Appeal Review’](#) information.

If the provider is submitting a post-service appeal on behalf of the member the FloridaBlue Appointment of Representative (AOR) form must be completed and accompany the appeal. /the appeal will then be processed as a member appeal. Please refer to [‘Member Commercial Appeal Review’](#) information.

General Appeal Guidelines

Administrative Appeals

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

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

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

- Out-of-network provider requesting additional payment without changing the claim's original billing information.
- Claims denied as being outside the provider's scope of service or contract
- Claims denied as services not payable under provider agreement
- Claims denied as services are not eligible for reimbursement

Claims are for a non-Florida Blue or non-Florida Blue HMO member (other Blue Plan)

For reconsideration of administrative appeals, you must adhere to the process guidelines and information provided below:

- All documentation associated with the claim must be submitted by the provider. This documentation is required at the time of appeal.
- All appeals must be submitted within one year of the date that appears on the respective remittance advice. Florida Blue will not overturn claim denials based on the provider's failure to comply with required procedures and timeframes.
- Non-participating providers submitting appeals for Medicare Advantage denials are required to submit a written appeal within 60 calendar days from the date of remittance advice.
- Providers may **not** balance bill members for covered services, including disputed amounts.
- If an appeal is overturned the claim is forwarded for adjustment and reprocessing.
- If the appeal is upheld the provider will receive written correspondence including the decision and outcome of the review.

The Provider will complete the [Provider Reconsideration/Administrative Appeal Form](#) as follows:

- Check one of the applicable Administrative Appeal Types as listed below:
 - Claim Allowance
 - Coordination of Benefits
 - Provider Contract Issue
 - Timely Filing
 - Other

All administrative appeals must include the following information:

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

Send all Administrative Appeals to

FloridaBlue
P.O. Box 1798
Jacksonville, FL 32231

Note: Requests for claim reprocessing is not an appeal. If the provider would like to submit a claim to be re-processed please follow the directions in the Claim Reimbursement section of the provider manual.

- Claims submitted for reprocessing are addressed in the [Claim Submission and Billing Guidelines](#) section of the provider manual.

Note: In the event Florida Blue receives a member **and** a provider appeal for the same service(s), the member appeal shall go forward and the provider or provider group appeal will be dismissed.

Provider Clinical Appeals

Clinical appeals are used for claims that have been denied for reasons including medical necessity,

experimental and investigational services, non-covered benefits, benefit exhaustion, and failure to obtain an authorization.

Providers are given an opportunity for one level of ***clinical and non-clinical appeal*** for claim denials eligible for appeal under the Provider Appeal Program. Providers must adhere to the process and information provided below:

- All supportive documentation must be submitted at the time of the appeal request.
- Duplicate requests will not be processed.
- Providers are encouraged to use the Provider Appeal form when submitting clinical appeals. Please see the [Provider Forms](#) section of the website and navigate to 'Appeals' menu to locate the appropriate instructions and form.

Non-Clinical Appeals

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

- Coding and Payment Rule Appeals

Lucet Behavioral Health Appeals Contact Information:

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

Post-Service Appeals - Provider

An adverse determination post-service appeal must be submitted in writing within one year of date of remittance advise.

Send all post service appeals to:

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

All post service appeals must include the following information:

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

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

- Florida Blue's member (or his or her representative) or the provider or provider group filed a pre-service appeal pertaining to the same denied service; or

- Florida Blue's member (or his or her representative) is currently seeking or has sought a review or filed litigation related to the same denied service. In the event either Florida Blue's member (or his or her representative) and the provider or provider group seek review of the same denied service, Florida Blue's member appeal shall go forward and the provider or provider group appeal will be dismissed.

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

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

Pre-Service Appeals – Member

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

Coding and Payment Rule Appeal

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

They do not refer to:

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

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

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

- The completed [Provider Clinical Appeal Form](#)
- A written explanation supporting the procedure code(s) appealed
- A copy of the remittance advice attached

- The necessary medical documentation (e.g., operative report, physician orders, history and physical) as indicated by the reason for the reduction or the denial on the remittance advice
- Documentation from a recognized authoritative source that supports your position on the procedure codes submitted (optional)

Send Coding and Payment Rule Appeals to

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

Utilization Management Appeals

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

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

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

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

Send UM appeals to:

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

Member Appeals

Member Commercial Plan Appeal Review Process

There may be occasions when a member engages the provider for assistance in completing a member appeal or grievance. The information in the following sections is intended to assist the provider during such requests from the member.

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

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

Florida Blue HMO Member Appeal General Rules

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

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

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

Florida Blue HMO shall offer to meet with the member if the member believes that such a meeting will help Florida Blue HMO resolve the grievance or appeal to the member's satisfaction. The meeting will be held at Florida Blue HMO's local office within the service area or at such other mutually agreeable location within the service area that is convenient to the member. The member may elect to meet with Florida Blue HMO representatives in person, by telephone conference call, or by video-conferencing (if facilities are available). Appropriate arrangements will be made to allow telephone conferencing or video conferencing to be held at the administrative offices of Florida Blue HMO within the service area. Florida Blue HMO will make

arrangements with no additional charge to the member. The member must notify Florida Blue HMO that he/she wishes to meet with Florida Blue HMO representatives concerning the grievance or appeal.

The member has the right to submit oral or written documents, records, or other information relating to their grievance or appeal.

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

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

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

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

Florida Blue HMO Member Grievance and Appeals

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

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

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

Grievances and Appeals Address

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

Member Standard Appeals

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

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

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

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

Member Pre-Service Appeals

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

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

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

Member Process for Requesting an Expedited Review

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

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

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

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

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

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

Member Medicare Appeals

Who May File an Appeal, Grievance, or Complaint?

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

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

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

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

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

- A member, or provider on behalf of a member, has the right to a pre-service benefit determination. In the event of an adverse determination, the provider may submit an appeal on a member's behalf by obtaining written permission from the member by completing the [Member Appeals Appointment of Representation Form](#). The member or provider should also complete the Medicare Advantage Grievance and Appeal Form and submit the forms to Florida Blue. Choose appropriate form for your coverage: [HMO Grievance & Appeal Form](#) or [Health Plan Grievance & Appeal Form \(Non-HMO\)](#). You can access these and other Medicare members forms on the [Medicare website](#).

Medicare Advantage Appeals – Non-Par Providers

Appeals for Medicare Advantage Non-Par Providers

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

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

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

Medicare Expedited 72-Hour Determination and Appeal Procedures

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

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

An expedited reconsideration may not be a request for payment.

Original Adverse Organization Determination Overturned:

If the expedited reconsideration determination is completely favorable to the member, Florida Blue notifies the member within 3 calendar days and mails a written confirmation letter. An extension of up to 14 calendar days is permitted for a 72-hour appeal, if the provider or the member asks for the extension, or if we need

more information and the extension of time benefits the member; for example, if a provider needs time to provide us with additional information.

Original Adverse Organization Determination Upheld:

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

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

You may mail your written appeal to:

Florida Blue
Attention: Medicare Appeals Department
P.O. Box 41629
Jacksonville, FL 32203-1629

Contact Information

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

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

Florida Blue
Attention: Medicare Appeals & Grievances Department
P.O. Box 41629
Jacksonville, FL 32203-1629

Member Grievance

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

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

Informal Review (Complaint)

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

Formal Review (Grievance)

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

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

Expedited Grievances

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

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

How to Request an Expedited 72 Hour Review

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

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

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

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

Compliance & Programs

Quality Programs

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

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

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

Medicare Stars Program

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

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

A Plan's star ratings are ranked 1- 5 in each category, then used to determine the plan's overall score:

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

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

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

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

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

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

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

Clinical Practice Guideline Monitoring and Improvement

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

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

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

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

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

Condition Specific Interventions and Programs

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

Financial Incentives Policy for Utilization Management Programs

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

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

Incident Reporting

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

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

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

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

Member and Provider Satisfaction Assessment

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

Comprehensive Quality & Risk Program (CQRP)

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

- Clinically-driven algorithms look back through two years of administrative and claims data to identify members who have chronic conditions and clinical and quality of care opportunities.
- Each identified member will have an associated Comprehensive Quality & Risk Health Assessment Form in Availity®¹ Payer Spaces Work Queue.
- The Panel Roster in Availity®¹ Payer Spaces delivers a view of the patient population with a health assessment form at the individual physician level within a provider group and physicians will receive email notifications indicating any updates to the panel roster.

- Physicians should contact their patients to schedule an appointment for an annual comprehensive health assessment.
- A comprehensive health assessment must be performed with the patient and the practitioner must fully complete, electronically sign the Comprehensive Quality & Risk Health Assessment Form with his/her credentials and submit through Availity®¹. Providers must also submit a claim to Florida Blue with applicable CPT, diagnosis and/or HCPCS codes for the comprehensive visit performed.

Preventive Health Monitoring and Improvement

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

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

Quality Performance Indicators

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

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

Under-Utilization and Over-Utilization Assessment

- CMS requires Medicare Advantage plans to facilitate delivery of appropriate care and monitor the impact of its UM programs to detect and correct potential under/over utilization of services. MA health plans using physician incentive plans that place a physician or physician group at substantial financial risk (as defined at 42 CFR 422.208(d)) should review utilization data to identify patterns of possible underutilization of services that may be related to the incentive plan.
- Under-utilization of services may exist when medical services vary substantially when physicians are compared to a peer group, or services are not provided according to the level specified in practice parameters, industry standards, or other benchmarks.
- Under and over utilization assessment is applicable to Florida Blue's HMO (Commercial and Medicare) products.
- We use several mechanisms to monitor under and over use of services.

Quality Improvement Organization

Quality Improvement Organizations (QIOs) are organizations comprised of practicing doctors and other health care experts under independent contract by the Centers for Medicare and Medicaid Services (CMS) to review the medical necessity, appropriateness and quality of medical care and services provided to original Medicare and MA beneficiaries by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies comprehensive outpatient rehabilitation facilities, Medicare managed care plans, and ambulatory surgery centers.

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

QIO Review of a Member's Hospital Discharge Appeal

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

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

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

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

Note: "Member" as used in this section includes a member's representative.

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

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

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

QIO Review of Quality of Service Complaints

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

KEPRO

5201 W. Kennedy Blvd., Suite 900

Tampa, FL 33609

Phone: (844) 455-8708

Fax: (844) 834-7129

Non-Participating Medicare Advantage Provider Appeals

Diagnostic Imaging Quality Program

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

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

Advanced Imaging Service (AIS) Providers Quality Program

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

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

Accreditation can be obtained by contacting the ACR or IAC at the websites below.

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

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

Hospital Readmission Review Quality Program

The Florida Blue Readmissions Review Quality Program is designed to foster better care as a path to reducing readmissions. It also aims to increase awareness of Florida Blue resources and assist facilities in identifying opportunities to help reduce preventable readmissions. We encourage contracted hospitals to collaborate with us and our community providers around this effort.

This program, which is a Florida Blue quality-of-care review process, will determine (i) if an admission is for treatment of the same or a related condition, or a procedure occurring less than 15 days from a prior admission's discharge and (ii) if the subsequent inpatient care could have been reasonably prevented by the provision of care consistent with accepted standards during the prior discharge planning and/or post discharge follow-up period. Additional details are available in the [Readmissions Review Quality Program Guide](#).

Audit Programs

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

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

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

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

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

- Compliance with contractual conditions and terms
- Appropriateness of coding (e.g., national coding standards; CPT, HCPCS, ICD9-CM, others as applicable)
- Unbundling of services/procedural codes (e.g., Hospital Charge Reimbursement Definitions, Correct Coding Initiative and code editing hardware)
- Billing accuracy
- Duplicate payments
- Member benefits, exclusions and coverage periods
- Claims processing guidelines

- Criteria supporting medical appropriateness of care and/or compliance with Florida Blue's Medical Policies (Medical Coverage Guidelines)
- Accuracy of the authorization and prior approval processes, where indicated or required
- Our payment methodologies

We may request medical records or supporting documentation in connection with an audit. If we request medical records, you will provide copies of those free of charge unless otherwise required by law or contract.

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

In House Audits

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

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

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

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

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

Provider Audit Process

Notification/Confirmation Responsibilities:

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

Note: Certain targeted audits are conducted without prior notification to the provider. In these instances the provider will have the opportunity to respond to the findings.

Provider Responsibilities:

We require formal acknowledgement of the notification of an audit. Acknowledgement should include:

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

Our Responsibilities:

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

Provider Responsibilities during the audit, the provider agrees to:

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

Audit Findings Our Responsibilities:

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

Provider Responsibilities:

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

Escalation Process

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

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

Exit Process

Our Responsibilities:

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

- Discussion of overpayment recovery process: Upon completion of the audit, repayment will be requested from the provider, to be mailed to the Florida Blue Overpayment Recovery lockbox with audit summary attached (refer to Overpayment Recovery) or recoupment may be initiated by offsetting refunds due to us.
- In cases where the provider requests the use of the offset payment methodology, no checks should be sent to us. Using the offset process will significantly reduce the potential for duplicate recovery processing.

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

Vendor Audits

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

Medicare Advantage Onsite Compliance Audits

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

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

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

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

Specialized Audits

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

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

Encounter/Claim Data Audits

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

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

Provider Non-Compliance/Penalties

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

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

Participating Providers Responsibility

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

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

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

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

assistance or funding from HHS and carriers who participate in the Federally-Facilitated Marketplace, Medicare Advantage, or Medicaid.

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

Discharge from PCP Practice (HMO and BlueMedicare HMO only)

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

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

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

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

If the Agreement is terminated:

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

Member Rights and Responsibilities

- To be provided with information about Florida Blue, our services, coverage and benefits, the contracting practitioners and providers delivering care, and members' rights and responsibilities.
- To receive medical care and treatment from contracting providers who have met our credentialing standards.
- To expect health care providers who contract with us to:
 - Discuss appropriate or medically necessary treatment options for a member's condition, regardless of cost or benefit coverage.
 - Permit a member to participate in the major decisions about his or her health care, consistent with legal, ethical and relevant patient-provider relationship requirements.
 - Advise whether a member's medical care or treatment is part of a research experiment, and to give a member the opportunity to refuse any experimental treatments; and
 - Inform a member about any medications he or she is told to take, how to take them, and their possible side effects.
- A member has the right to receive emergency care that a member, as prudent layperson acting reasonably, would have believed that an emergency medical condition existed. Payment will not be withheld in cases when, acting reasonably, a member seeks emergency medical services.
- A member has the right to receive urgently needed services when traveling outside the service area or in the service area when unusual or extenuating circumstances prevent a member from obtaining care from an in-network provider.
- Become familiar with coverage and the rules that must be followed to get care as a member.
- Attempt to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Give doctors and other providers the information they need to provide care; and to follow the treatment plans and instructions for care that they have agreed upon.
- Act in a way that supports the care given to other patients and helps the smooth running of the doctor's office, hospitals, and other offices and not be disruptive.
- Pay plan premiums and any copayments, deductibles and applicable coinsurance owed for the covered services received. A member must also meet other financial responsibilities that are described in the Member Handbook.
- Follow established processes for filing an appeal or grievance concerning medical or administrative decisions that he or she feels are in error
- To expect courteous service from Health Options and considerate care from contracting providers with respect and concern for a member's dignity and privacy.
- To voice his or her complaints and or appeal unfavorable medical or administrative decisions by following the established appeal or grievance procedures found in the Member Handbook or other procedures adopted by Florida Blue for such purposes.
- To inform contracting providers that he or she refuses treatment, and to expect to have such providers honor his or her decision if he or she chooses to accept the responsibility and the consequences of such a decision. Members are encouraged (but not required) to:
 - Complete an advance directive, such as a living will and provide it to the contracting plan providers; and
 - Have someone help make decisions, to give another person the legal responsibility to make decisions about medical care on a member's behalf.

- To have access to your records and to have confidentiality of your medical records maintained in accordance with applicable law.
- To call or write to us any time with helpful comments, questions and observations whether concerning something you like about our plan or something you feel is a problem area. You also may make recommendations regarding Florida Blue members' rights and responsibilities policies. Please call the number or write to us at the address on your membership card.
- (BlueCare/HMO only) Seek all non-emergency care through his or her assigned PCP, or through a contracting physician and to cooperate with all persons providing care and treatment.
- Be respectful of the rights, property, comfort, environment and privacy of other individuals and not be disruptive.
- Take responsibility for understanding his or her health problems and participate in developing mutually agreed upon treatment goals, to the extent possible, then following the plans and instructions for care that are agreed upon with a member's Florida Blue provider.
- Provide accurate and complete information concerning a member's health problems and medical history and answer all questions truthfully and completely.
- Be financially responsible for any copayments and non-covered services, and to provide current information concerning enrollment status to any Florida Blue-affiliated provider.
- Follow established procedures for filing a grievance concerning medical or administrative decisions that he or she feels are in error.
- Request his or her medical records in accordance with Florida Blue rules and procedures and applicable law.
- Review information regarding covered services, policies and procedures as stated in the Member Handbook.

Member Rights under BlueMedicare HMO and BlueMedicare PPO Products

1. Right to be treated with fairness and respect
 - a. A member has the right to be treated with dignity, respect, and fairness at all times. We do not discriminate against members based on race, sex, color, ethnicity, national origin, religion, sexual orientation, gender identity or expression, age, mental or physical disability, veteran status, marital status, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.
2. Right to access medical records
 - a. A member has the right to access medical records and get a copy of those records. Federal and state laws protect the privacy of a member's medical records and personal health information. Florida Blue keeps member personal health information private as protected under these laws, and makes sure that unauthorized people do not see or change a member's records. Generally Florida Blue must get written permission from a member before we can give a member's health information to anyone who is not providing care or paying for care. A member has the right to ask providers to make additions or corrections to medical records. If a member asks providers to do this, providers will review a member's request and decide whether the changes are appropriate. A member has the right to know how health information has been given out and used for non-routine purposes.

3. Right to see in-network and out-of-network providers and obtain covered services within a reasonable amount of time
 - a. A member has the right to choose a provider for care. A member has the right to timely access to providers and to see specialists when care from a specialist is needed. Timely access means a member can get appointments and services within a reasonable amount of time.
4. Right to know treatment choices and participate in decisions about health care
 - a. A member has the right to get full information from providers when going for medical care, and the right to participate fully in decisions about health care. Providers must explain things in a way that a member can understand. Rights include knowing about all of the treatment choices that are recommended for the condition, no matter what they cost or whether they are covered under BlueMedicare HMO or BlueMedicare PPO. A member has the right to be told about any risks involved in care. A member must be told in advance if any proposed medical care or treatment is part of a research experiment and be given the choice of refusing experimental treatments.
 - b. A member has the right to receive a detailed explanation from Florida Blue if a member believes that a plan provider has denied care that a member believes he or she is entitled to receive or care a member believes he or she should continue to receive. In these cases a member must request an initial decision.
 - c. A member has the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if the doctor advises a member not to leave. If a member refuses treatment, a member accepts responsibility for what happens as a result of refusing treatment.
5. Right to use advance directives (such as a living will or a power of attorney)
 - a. A member has the right to ask someone such as a family member or friend to help with decisions about his or her health care. If a member chooses, he or she can use a special form to give someone the legal authority to make these decisions.
6. Right to make complaints
 - a. A member has the right to make a complaint if a member has concerns or problems related to coverage or care. Appeals and grievances are the two different types of complaints a member can make that depend on the situation. If a member makes a complaint, Florida Blue must treat a member fairly, and not discriminate against him or her because of the complaint. A member has the right to get a summary about the appeals and grievances that other members have filed in the past against Florida Blue in its capacity as a Medicare Advantage organization.
7. Right to get information about health care coverage and costs
 - a. A member's "Summary of Benefits" and "Evidence of Coverage" explain what medical services are covered as a plan member and what a member has to pay. A member has the right to an explanation from Florida Blue about any bills for services not covered by Florida Blue. Florida Blue must tell a member in writing why Florida Blue will not pay for or allow a member to get a service and how to file an appeal to ask for the decision to be changed.

8. Right to get information about Florida Blue, BlueMedicare plans, and in-network providers
 - a. A member has the right to get information from us about Florida Blue and about BlueMedicare HMO or BlueMedicare PPO. This includes information about our financial condition, about health care providers and their qualifications, and about how BlueMedicare plans compare to other health plans. A member has the right to find out how Florida Blue pays in-network providers. Members may contact us any time with helpful comments, recommendations and/or questions about our members' rights and responsibilities policies. Florida Blue has free language interpreter services available to answer questions from non-English speaking members.
9. Right to receive emergency care and urgently needed services
 - a. A member has the right to receive emergency care that a member, as prudent layperson acting reasonably, would have believed that an emergency medical condition existed. Payment will not be withheld in cases when, acting reasonably, a member seeks emergency medical services.
 - b. A member has the right to receive urgently needed services when traveling outside the service area or in the service area when unusual or extenuating circumstances prevent a member from obtaining care from an in-network provider.

Confidentiality of Member Information

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

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

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

Self Service

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

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

Electronic Self-service tools

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

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

Electronic Capability and Participation

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

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

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

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

Health Plan Transactions

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

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

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

Government Connections

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

Other Blue Plans

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

Florida Blue Hours of Availability for Electronic Transactions

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

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

Sunday 12 a.m. – 5 p.m. Eastern Time

Hours of operation for claim status inquiries are:

Monday through Saturday 24 hours a day

Sunday 12 a.m. – 5 p.m. Eastern Time

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

Administrative Solutions

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

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

Authorizations

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

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

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

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

Tips for Faxing a Cover Sheet Digitally

- Important: Make sure the cover sheet is the first page. If you fax a digital copy, the fax cover sheet must be inserted as the first page before any other documents or the scanning system will not be able to read it. If another document is inserted as the first page, your request will default to the standard precertification fax number, and your review may take longer.
- Make sure the authorization or reference number on the cover sheet is correct. This is very important. If the number isn't right, a review of the authorization request could be delayed.
- Do not fill out the automated fax cover sheet by hand. The scanning system cannot recognize data that is written by hand.

Tips for Faxing a Paper Cover Sheet

- After saving the data, click on the "Print" button to get a copy of your pre-populated fax cover sheet.
- Important: Make sure the cover sheet is placed on top of any medical records or other information that you plan to fax to us. If another document is the first page, your fax will go through the standard precertification system, and your review may take longer.
- Make sure that the authorization or reference number on the cover sheet is correct. This is very important. If the number is not right, a review of the authorization request could be delayed.
- If you don't print the fax cover sheet right away when you receive a Requires Medical Review message, you can do an Authorization/Inquiry later in Availity® to access the Automated Fax Cover Sheet button.

Accessing the New Fax Cover Sheet Through floridablue.com

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

Eligibility & Benefits Inquiry and Response

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

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

- The Eligibility and Benefits results screen provides access to Patient Cost Estimator, Patient Cost Estimator Facts, Patient Care Summary, FB Products & Plans, Care & Coding Reminders and Medical Coverage Guidelines.

Eligibility & Benefits Patient Care & ICD-10 Coding Reminders

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

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

Eligibility & Benefits Inquiry Screen

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

Streamline the way you key and submit an Eligibility & Benefits (E&B) Inquiry by following a few simple guidelines and helpful hints.

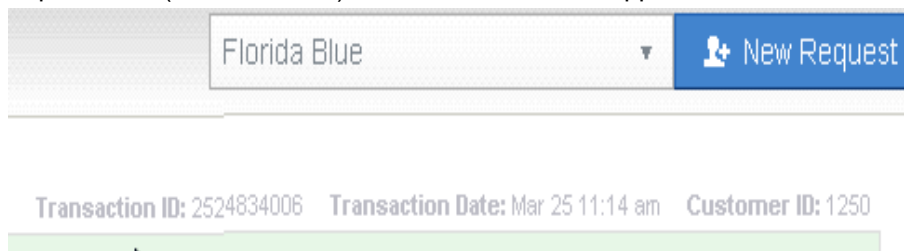
- Take time to be precise. Using shortcuts can cause keying errors, resulting in the need to re-keying or submit information multiple times.
- Be certain to key the most current member data correctly the first time as it appears exactly on the ID card. (Please note: middle initial is not required) Keying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

Fast Path Priority Service for Eligibility and Benefits (E&B)

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

Fast Path Priority Service process for E&B

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



New Claim Status Tool

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

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

Helpful Hints:

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

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

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

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

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

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

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

Once clicked, the details are available in the right pane in the viewer. Review and scroll to see information about the claim detail lines, such as itemized distribution, HIPAA codes, Florida Blue remarks, revenue codes and other pertinent claim and claim line details.

Note: You can hover over the (i) icons to see expanded descriptions of indicators and remarks.

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

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

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

Need more information about the remittance? To check remittance:

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

Fast Path Priority Service process for NCS

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

- Complete an electronic NCS transaction, and then scroll to the bottom of a claim detail card to retrieve the fast path code (transaction ID).

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

Claim Status

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

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

Claim Reconciliation Tool

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

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

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

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

To access the CRT link, please follow these steps:

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

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

The claim status types available include:

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

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

- Contract Number
- Patient Account Number
- Patient Last Name

Note: If you do not request the claim results be sorted by one of the three above choices, then your results will be sorted by the Date of Service.

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

- Disable pop-up blockers – Some offices may have multiple pop-up blockers under different navigation bars (e.g., Google, Yahoo!). These can be turned off and will provide access to the CRT. When you finished with the tool, you can turn on pop-up blockers.
- Allow Availity® as a trusted site – To avoid turning on and off pop-up blockers, you can open the Internet Options on a browser window and can add www.Availity®.com as a trusted site.
- Manually bypass pop-up blockers – If the above options do not work or there seems to be a hidden pop-up blocker that cannot be found, you can hold down the “Ctrl” button and then select the “Next” button. This will bypass the pop-up blocker and the user should see the CRT disclaimer window.

Fast Path Priority Service for Claims Reconciliation Tool (CRT)

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

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

From Service Date	To	Procedure	Procedure Modifier	ICD9 Code	Amount Billed	Amount Paid	Allowed Amount	Patient Deductible	Patient Co-Ins	Patient Co-Payment	Non-covered Charges	Patient Responsibility	Remarks
10/29/2009	10/29/2009	88305		F2123	160.00	0.00	139.30	0.00	0.00	0.00	139.30	0.00	CADEV

Clear Claim Connection

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

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

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

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

How to Use Clear Claim Connection

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

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

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

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

Care Read

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

Telephone Self-service tools

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

Telephone Self-Service Tips

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

Claims List –Self-Service Commands

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

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

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

Eligibility & Benefits List – Benefit Information

Contract Information Disclosed:

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

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

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

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

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

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

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

Eligibility and Benefits Menu Options	Speak the key words below:
Get benefits for Professional medical services rendered in an office setting:	<p>"Professional"</p> <ul style="list-style-type: none">▪ "Sick Office Visit"<ul style="list-style-type: none">• "Consultation Only"• "Dermatology"• "Medical Pharmacy"• "Professional Office Visit"• "Sick Office Visit"▪ "Well Office Visit"<ul style="list-style-type: none">• "Gynecological"• "Medical Care"• "Professional Physician"• "Professional Office Visit"

	<ul style="list-style-type: none"> • “Well Office Visit” “Pediatric” “Chiropractic” “Maternity” “Allergy” <ul style="list-style-type: none"> • “Allergy” • “Allergy Testing”
Get benefits for Facility services.	“Facility” “Hospital Outpatient” “Hospital Inpatient” “Emergency Services” “Rehabilitation” “Ambulatory surgery center” “Skilled Nursing Care”
Get benefits for DME, or Durable Medical Equipment.	“DME” “Purchase” “Rental” “Both”
Get benefits for Physical Therapy services.	
Get benefit details based on “Diagnostic” Service Type	“Diagnostic” “MRI” “CT Scan” “X-ray” “Laboratory”
<i>(continued on next page)</i>	
Get benefit details based on “Mental Health” Service Type	“Mental Health” “Provider Outpatient” “Provider Inpatient” “Facility Outpatient” “Facility Inpatient” “Hear them all”

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

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

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

Availity® Issues:

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

Other Resources

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

Frequently Used Telephone Numbers and Information:

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

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

[Quick Reference Contact Guide](#)

Electronic Claim Submission

Electronic Claim Submission allows providers to safely submit and track HIPAA-compliant electronic claims to Florida Blue via [Availity®](#) without manual intervention.

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

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

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

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

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

Note: Allow 30-days for receiving payment from Medicare and the Blue Plan before you resubmit Medicare Supplement claims. Accurate and complete claims, which include National Provider Identifiers, cross over

to our system after Medicare processes them. Medicare releases the claim to the Blue Plan secondary payer for processing when they send your Medicare remittance notice.

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

Electronic Submission of Corrected Claims

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

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

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

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

7 – Replacement /Update of a Prior Claim

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

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

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

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

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

8 – Void/Cancel of Prior Claim

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

Professional Real-Time Claim Adjudication

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

Information to consider when submitting a RTCA transaction:

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

RTCA Messages

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

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

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

Clinical Solutions

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

Authorization and Referrals Inquiry, Update and Voids

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

Inquiries

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

To inquire about existing service requests:

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

Referral Tool Enhancement for PCPs Choosing Specialists for Members

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

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

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

How to Demo the Referral Tool

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

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

Updates

To update existing requests:

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

Changes can be made only when:

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

The select fields that can be updated are:

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

How to Void (Cancel) Existing Requests

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

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

eCensus Tool

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

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

How to Get Started

Visit [Availity®](#) to view a 3.5-minute eCensus demo. Click Help & Training | Get Trained, and search by keyword eCensus.

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

ProviderVista

ProviderVista is an easy-to-navigate population health management portal offering access to a consolidated view of a primary care physician's commercial and Medicare Advantage patients. Providers can view and download utilization information, manage open care measures, review census information, check care alerts, view risk adjustment diagnosis coding opportunities and more. ProviderVista also has a two-way communication feature that facilitates care gap closures.

To use ProviderVista, log in to [Availity®.com](#), go to *Payer Spaces*, then *Florida Blue*, and select the *ProviderVista* tile. If you do not see the tile, your Availity® practice administrator (PAA) can grant access. To find your PAA, select the “*Who controls my access?*” hyperlink at the top of the Availity® screen. After access is granted, log back in to [Availity®.com](#). Resources and self-guided learning materials are available on the Florida Blue Learning Center and on Florida Blue's Payer Space. For questions or to request training, call 800-727-2227 and say “*ProviderVista*” when prompted.

Electronic Appeal

Submit appeals for previously processed claims electronically with electronic appeals.

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

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

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

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

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

Electronic Care Reminders

Care Reminders are clinical messages based on claims data that can be found within a Patient Care Summary and are intended to assist with identifying opportunities to improve the health of patients. The

current electronic Care Reminders are based on Healthcare Effectiveness Data and Information Set (HEDIS) and the Centers for Medicare & Medicaid Services (CMS) Star measures.

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

Clinical Quality Validation Forms

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

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

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

Patient Care Summary

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

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

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

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

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

- Supports coordination of care by allowing a treating physician to view certain services rendered by other providers.
- Complements the physician's own medical record by filling in gaps in the patient's medical history.
- Facilitates dialog with the patient.
- Helps reduce duplicate medical procedures, unnecessary services and health care costs.

- Alerts the physician to indicators of under-use, overuse or misuse of health care services.
- Is accessible from any location by authorized users even in times of catastrophic events so that appropriate treatment or service can be delivered to patients.

Financial Solutions

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

Patient Cost Estimator

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

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

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

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

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

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

- Organizations that have multiple facilities/ambulatory surgery centers with one NPI mapped multiple Florida Blue provider numbers with multiple fee schedules.

Other Blue Plans

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

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

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

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

Patient Cost Estimator Messages

The following actions should be taken when Patient Cost Estimator responds with the below messages:

- "Unable to determine patient liability, additional information is required. You may submit this transaction as a claim, further review maybe required." For a Florida Blue or out of state member:
 - Review and confirm the information submitted in the Patient Cost Estimator inquiry (e.g., Have you entered an unlisted procedure code?). Make corrections as necessary. If you are still unable to determine patient liability, it is possible that manual review of the claim is necessary to determine appropriate coverage and pricing. If all information appears correct, contact the Provider Contact Center.
- "Unable to determine patient liability; additional information is required" for an out-of-state member
 - Patient Cost Estimator may return this error message on the Patient Cost Estimator inquiry screen when a response from the member's Home Plan is not received timely or the transaction has timed out. Please reviews the information submitted and resubmits at a later time.

- "Deny PA Group Claims"
 - Message applies to professional only
 - The provider rendering services is part of a group that will be paid for the services rendered. This will require you to provide the appropriate information for both the rendering provider and the group. For the rendering provider, return to the Eligibility and Benefits inquiry screen and populate the rendering NPI number for the provider who is rendering services in the NPI field.
 - For the group, on the Patient Cost Estimator inquiry screen Provider select the Group Tax ID option in the Pay-To Provider Information section and enter your group's tax ID number in the Tax ID field.
- "COB information is not current"
 - It is the member's responsibility to provide other insurance information to Florida Blue annually. A form is mailed to members to complete or they can update their other insurance information online. As with any other calculation, Patient Cost Estimator will determine an estimated member responsibility for those members who have not updated their other insurance information, but there is a higher likelihood that this amount may be different than the amount determined after the claim processes.
 - The [Coordination of Benefits Questionnaire](#) form is available on our website. You can print this form for your patients to complete and mail to Florida Blue.

Medical Services Requiring Authorization or Pre-Service Review

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

Professional Patient Cost Estimator Specifics

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

Electronic Funds Transfer

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

- Quicker access to your claim payment funds
- Elimination of lost or stolen checks
- Increased administrative efficiencies and greater convenience
- Increased security of information

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

To register for the EFT service go online to www.Availity®.com and attach a voided check or bank letter. Additional instructions and definitions pertaining to Electronic Funds Transfer can be found [here](#).

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

If you are requesting direct deposit into multiple bank accounts, you will need to complete an online registration *for each office location and associated bank account*.

EFT registration takes approximately one week from the date of receipt.

Once registered for EFT:

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

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

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

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

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

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

Electronic Remittance Advice

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

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

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

Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) are reported on the 835 ERA instead of payer's proprietary adjustment reason and denial codes. These standard reason and remark codes advise providers why payment may be different than the submitted charge. CARCs and RARCs are mandated by HIPAA-AS and the code definitions cannot be changed by Florida Blue or any payer. Some CARC definitions can be more generic than Florida Blue proprietary codes while RARC definitions provide more specific information related to adjudication of the claim. Both CARC and RARC codes are used industry wide to avoid payer specific language. There are certain generic CARCs reported on the 835 ERA that require at least one accompanying RARC to be returned as well which will provide clear information regarding when claim payments are denied or reduced. To obtain the most recent and complete list of CARCs and RARCs, visit the [Washington Publishing Company](#) website.

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

Remittance Viewer

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

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

Member Solutions

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

Member Website where members can login to:

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

Member Tools

Care Comparison

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

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

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

Data

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

Methodology

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

Bundles

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

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

Care Comparison Exclusions:

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

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

Procedures (Bundles) Included in Care Comparison

Procedure Name	Category
Arm - MRI Upper Limb	Diagnostic Radiology
Back - MRI Spine	Diagnostic Radiology
Back Surgery - Laminectomy	Inpatient
Back Surgery - Laminectomy	Outpatient
Back Surgery - Spinal Fusion (Lower Back)	Inpatient
Back Surgery - Spinal Fusion (Upper Back)	Inpatient
Bariatric Surgery - Lap Band	Outpatient
Bariatric Surgery - Laparoscopic Gastric Bypass	Inpatient
Bladder Repair for Incontinence (Sling)	Outpatient
Breast - Biopsy using a special probe	Outpatient
Breast - Needle Biopsy (with Imaging)	Outpatient
Breast Lumpectomy	Outpatient
Bronchoscopy	Diagnostic/Outpatient
Bunionectomy	Outpatient
Cardiac Angioplasty - w/ Drug Eluting Stent	Inpatient
Cardiac Defibrillator Implant w/o Cardiac Catheterization	Inpatient
Childbirth - Normal Cesarean Section Delivery	Inpatient
Childbirth - Normal Vaginal Delivery	Inpatient
Colon - Colonoscopy with biopsy	Diagnostic/Outpatient
Colon - Screening Colonoscopy	Diagnostic/Outpatient
Coronary Bypass (CABG) w/o Cardiac Catheterization	Inpatient
Dilation & Curettage - D&C	Outpatient
Ear - Insertion of ventilating tube	Outpatient
Eye Surgery - Cataract Removal	Outpatient
Gall Bladder - Removal (by Laparoscope)	Outpatient
Groin - Hernia Repair 5 Years and Older	Outpatient

Procedure Name	Category
Hammertoe Correction	Outpatient
Hand Surgery - Carpal Tunnel	Outpatient
Head - CT Scan Head	Diagnostic Radiology
Head - MRI Brain	Diagnostic Radiology
Heart - Left Catheterization	Outpatient
Hip Replacement - Joint Replacement Surgery	Inpatient
Hysterectomy	Inpatient
Knee - Cartilage Repair (using Arthroscopy)	Outpatient
Knee - Ligament Repair (Anterior Cruciate Ligament Repair by Arthroscopy)	Outpatient
Knee Replacement- Joint Replacement Surgery	Inpatient
Laparoscopic Removal of Ovaries and/or Fallopian Tubes	Outpatient
Laparoscopic Tubal Block or Tubal Ligation	Outpatient
Leg - MRI Lower Limb	Diagnostic Radiology
Lithotripsy - Fragmenting of Kidney Stones	Outpatient
Lower Limb with Joint – MRI	Diagnostic Radiology
Mammography – Analog	Diagnostic Radiology
Mammography Digital	Diagnostic Radiology
Nasal/Sinus- Corrective Surgery Septoplasty	Outpatient
Nasal/Sinus- endoscopy Sinus Surgery	Outpatient
Pelvis - CT Scan Pelvis	Diagnostic Radiology
Shoulder - Rotator Cuff Repair (using Arthroscopy)	Outpatient
Shoulder - Surgical examination (using Arthroscopy)	Outpatient
Stomach - CT Scan Abdomen	Diagnostic Radiology

Procedure Name	Category
Stomach - Upper Digestive Tract examination (using Endoscopy with Biopsy)	Diagnostic/Outpatient
Stomach - Upper Digestive Tract examination (using Endoscopy)	Diagnostic/Outpatient
Tonsils and Adenoids - Removal, under age 12	Outpatient
Urethra and Bladder Scope	Diagnostic/Outpatient

How to Avoid Provider Identification Errors

For Claims Involving NPI and Tax ID Number

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

Billing Provider Section

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

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

Rendering Provider Section

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

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

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

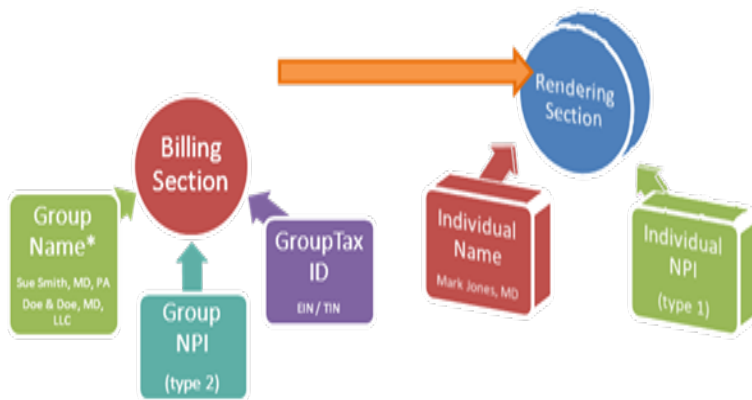
Billing as a Group Provider

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

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

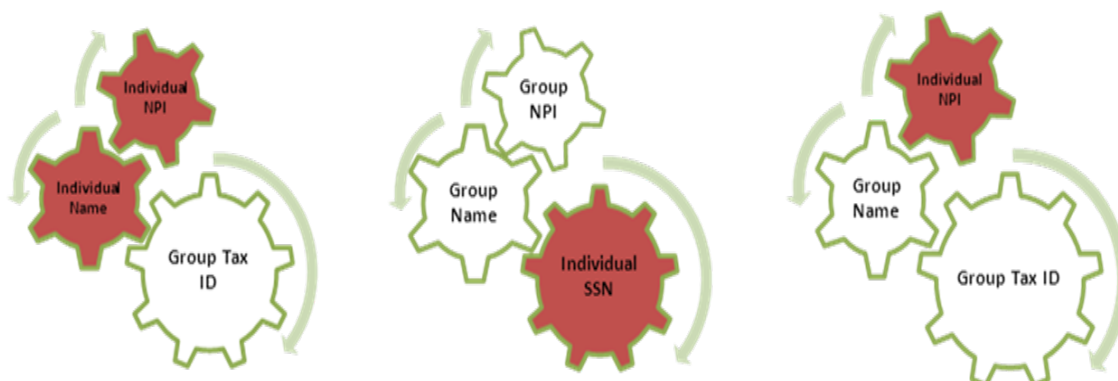
Correct Entry (The Match)

This example shows how the information submitted matches data registered with Florida Blue. The Group Name matches Group NPI which matches Group Tax ID number and all match Florida Blue provider files.



Incorrect Entries (The Mismatch)

Below are examples of information that will result in a mismatch of data causing a WEBV040 provider correctable error ultimately resulting in a delay in payment. The mismatch is highlighted in red.



Remember: Group Name = Group NPI = Group Tax ID Number

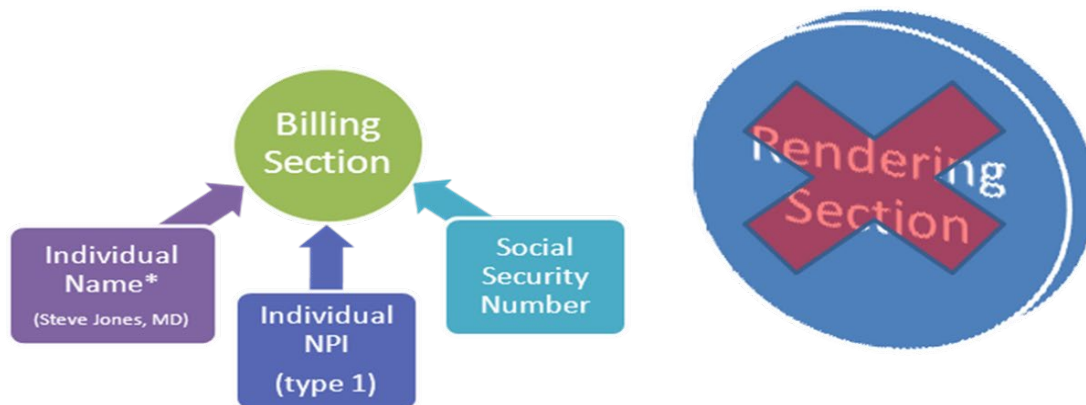
To confirm how you are registered with Florida Blue, please call the Provider Contact Center at (800) 727-2227, select option 5, and then option 2. If you would like to register a different Tax ID number, please complete the Provider Information Update Form (sections 1 and 6.) A completed IRS confirmation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

Billing as an Individual Provider Option 2

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

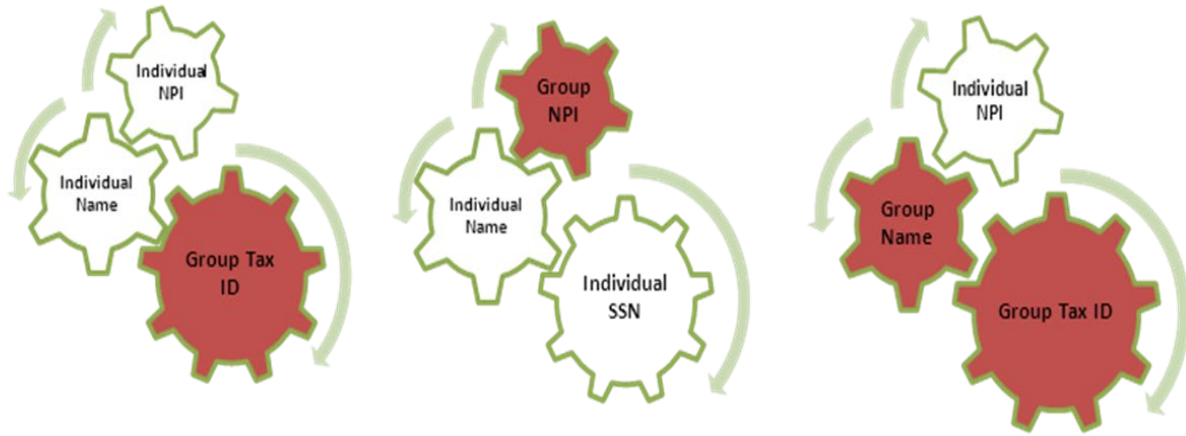
Correct Entry (The Match)

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



Incorrect Entries (The Mismatch)

Below are examples of information entered that will result in a mismatch of data causing a delay in payment. The mismatch is highlighted in red.



REMEMBER: Individual Name = Individual NPI = Individual Social Security Number

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

Ancillary Billing with NPI

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

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

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

Ancillary provider with registered employed health care providers:

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

Ancillary Provider with no registered employed health care providers:

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

Florida Blue NPI Attribute Matrix and Legend

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

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

NPI Attributes Technical Information

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

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