

Coding and Filing Claims

Introduction

This section of the *Manual for Physicians and Providers* explains certain aspects of the claim process. It includes guidelines for coding specific claims (e.g., unclassified drugs, well child, coordination of benefits), as well as information on claims processing, such as, electronic funds transfer and the remittance advice.

For additional provider specific billing and coding information, refer to Part II of the Manual.

Medical Coverage Guidelines

BCBSF processes claims based on the member's eligibility, benefits, and the medical necessity of the service provided. Evidence-based Medical Coverage Guidelines are used to help determine coverage under the medical necessity provisions of member contracts and Certificates of Coverage. In developing its Medical Coverage Guidelines, BCBSF looks to current best available external clinical evidence, specialty societies, physician consultants, the Food and Drug Administration, and the Blue Cross and Blue Shield Association.

Note: CMS establishes its own medical guidelines mandated by law for Medicare beneficiaries. Although the criteria for reviewing services may be similar, the Medicare medical guidelines and the BCBSF Medical Coverage Guidelines are not interchangeable.

Medical Coverage Guidelines are available on the BCBSF website, www.bcbsfl.com. Look for notification of periodic updates in the "What's New" section of the Medical Coverage Guidelines.

Medical Coverage Guidelines can also be obtained through the Availity Health Information Network. When receiving Eligibility & Benefits summary results, click on the Coverage Guidelines link located at the bottom of the screen.

Procedure and Diagnosis Codes

A critical element in claims filing is the submission of current and accurate codes to reflect the services provided. Correct coding is essential for correct reimbursement. We encourage you to purchase current copies of Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and International Classification of Diseases-9th Revision-Clinical Modification (ICD-9-CM) code books.

As a courtesy to our providers, the Discounts from Blue program features discounts on coding reference books software and other reference materials. Find out more information about the offerings and ordering instructions at www.providerdiscounts.rsvpbook.com. To login, enter the requested information and Special Code 33207V.

Unlisted Procedure Codes

Report an unlisted code only if unable to find a procedure code that closely relates to or accurately describes the service performed. Whenever you submit an unlisted code, you must include a written description of the services with the claim. Unlisted codes require documentation and therefore should not be submitted electronically; the exception is unclassified HCPCS drug codes (refer to Unclassified Drugs).

Code Updates

The American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) update procedure codes to reflect changes in health care and medical practices. Coding updates occur quarterly with the largest volume effective January 1 of each year. CPT and HCPCS codes may be added, deleted, or revised with each update.

ICD-9-CM updates may occur biannually with the largest volume effective October 1 of each year.

Coding Assistance

If you have questions regarding diagnosis, procedure or modifier codes, complete the [Coding Assistance Request Form](#), available on our website, www.bcbsfl.com, and fax to the number indicated on the form.

Modifiers

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

BCBSF processes claims using only the first two modifiers submitted. While up to four modifiers are accepted, claims are processed using only modifiers in the first and second position. Therefore, submit modifiers affecting reimbursement in the first and second position on paper and electronic claims.

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

Modifiers may be used to indicate that:

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

Online Medical Evaluation

An online medical evaluation is an evaluation and management (E/M) service provided by a physician to a patient, using the Internet or similar electronic communications in response to an established patient's online inquiry. This service should be billed with CPT code 99444 or 98969.

Such services involve:

- The physician's personal and timely response to the patient's inquiry,
- Permanent storage (electronic or hard copy) of the eMedicine encounter.

This service should not be reported for routine patient contacts (e.g., telephone calls, prescription refill requests) or pre-service or post service work for other E/M or non-E/M services. For additional information, refer to eMedicine in the [Electronic Self-Service Tools section](#).

BCBSF may reimburse for an online medical evaluation when certain criteria are met. For more information, review the eMedicine [Medical Policies \(Medical Coverage Guidelines\)](#) available at www.bcbsfl.com.

Immunizations and Injections

It is appropriate when administering an immunization or injection to bill administration codes (90465-90474, 96372). Reimbursement for immunizations and immunization administration is allowed in addition to preventive medicine services (99381-99397) and newborn care services (99460, 99461, 99463).

Visits for Immunizations Only

If only an immunization is administered, bill the CPT code for the immunization(s) administered and the applicable CPT administration code(s) (90465-90474).

Example:

A 40-year-old patient comes to your office just for a flu vaccine. Bill the vaccine code 90658 and administration code 90471.

Visits for Immunizations and E/M

Reimbursement for immunizations and immunization administration is allowed in addition to preventive medicine services (99381-99384, 99391-99394) and newborn care services (99431, 99432, 99435).

E/M codes 99201-99205 and 99212-99215 are eligible for separate reimbursement when billed on the same date of service as immunization codes 90476-90749 and the immunization administration codes 90471-90474. E/M code 99211 is not reimbursed separately when reported with immunization administration codes. For 99211 to be reimbursed separately, an appropriately reported modifier 25 would be required on 99211, indicating a separate, identifiable E/M service was performed.

Examples:

1. A three-year-old patient returns for a follow-up visit for an ear infection. At the follow-up visit, a DPT immunization is administered. Bill the immunization code 90720, the administration code 90471 and the appropriate E/M code and modifier 25.
2. A one-year-old established patient has a preventive visit and a polio vaccine. Bill the appropriate preventive visit CPT code (i.e., 99392), the polio vaccine (i.e., 90712) and in this case, the oral administration code (90473).

Therapeutic Injections

Bill the injection code, the appropriate injection administration code and the appropriate E/M code, if applicable. E/M codes are only reimbursed separately when reported with an appropriately billed modifier 25 indicating a separate, identifiable E/M service was performed.

Example:

A 75-year-old patient with a documented diagnosis of pernicious anemia comes to your office for a visit for a B-12 injection. You also do a follow-up on her hypertension. Bill the B-12 injection code (J3420), the administration code (90471) and the appropriate E/M code with modifier 25 (in this case, 99211-99215).

Unclassified Drugs

An unclassified drug is defined as a drug that does not have a specific, designated HCPCS code. Unclassified HCPCS codes should only be used when there is not a specific HCPCS code available for the drug being billed. Submitting a claim with an unspecified HCPCS code when there is a designated HCPCS code for that drug will result in a denial of payment.

The following are guidelines for providers who submit unclassified drug codes on the CMS-1500 claim form or its electronic equivalent:

- Use the appropriate unclassified drug HCPCS code (e.g., J3490, J3590, J8999, etc.)
- Enter the following National Drug Code (NDC) information:
 - NDC Qualifier (N4)
 - NDC Code (11 digits – see below)
 - NDC Description (optional)
 - NDC Quantity using a metric decimal quantity (reported in the HCPCS units) as administered to the member.

Report the NDC Code in an FDA recognized 11-digit numeric format, usually seen in a 5-4-2 format; e.g., 99999-9999-99. Occasionally, NDCs are in 10-digit format. Providers must convert 10-digit NDCs to 11 digits using the following methodology:

If 10-digit NDC format is:	Then add a zero (0) in:	Report NDC as:
4-4-2 (9999-9999-99)	first position, 0 9999-9999-99	09999999999
5-3-2 (99999-999-99)	sixth position, 99999- 0 999-99	99999099999
5-4-1 (99999-9999-9)	tenth position, 99999-9999- 0 9	99999999909

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

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

Electronic Claims (837 Professional Format)

HCPCS Procedure Codes

Technical details for the 837p Loops for the HCPCS code and HCPCS units:

- HCPCS code in Loop 2400, Segment SV1, Element SV101= HCPCS Code
- HCPCS units in Loop 2400, Segment SV1, Element SV104= HCPCS Units (e.g. HCPCS units do not exist for unclassified drugs. **NDC Quantity is required in this element.**

Note: The NDC Quantity can be a decimal amount.

NDC Qualifier and NDC Code

Bill the NDC qualifier (N4) and NDC Code (11-digits using 5-4-2 format [e.g., 5-digits, followed by 4-digits, followed by 2-digits]. Do not include any hyphens or spaces (e.g., 01234567891).

Technical details for the 837p Loops for the NDC Qualifier and NDC Code:

- NDC Qualifier in Loop 2410, Segment LIN, Element LIN02 = N4
- NDC Code in Loop 2410, Segment LIN, Element LIN03 = 11 digit NDC Code (e.g., LIN**N4*01234567891)

CMS-1500 Paper Claims

24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS ON UNITS	H. EPST Part 1	I. ID. QUAL	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER							
N415054012002	SOMATULINE DEPOT 120MG/0.5ML			SYR					14	965	09	.5	N	1B	99999
06	29	08	06	29	08	11	J3490						N	NPI	0123456789

HCPCS Procedure Code

Specific locations on the CMS-1500 form for the HCPCS code and the HCPCS units:

- HCPCS code in the lower, non-shaded area of Block 24D.
- HCPCS units do not exist for unclassified drugs. **NDC Quantity is required in Block 24G.**

Note: In the example listed above, the NDC quantity in Block 24G is not a whole number.

NDC Qualifier and NDC Code

Specific locations on the CMS-1500 form for the NDC Code and Description:

- In the *shaded area* of Block 24A enter the “N4” qualifier, then the NDC Code, and drug description starting in the first space of the shaded area of Block 24A. Do not enter a space between the qualifier and the code (e.g. **N415054012002**).
- The NDC Description *follows* the NDC Code (e.g. N415054012002 **Somatuline Depot 120MG/0.5ML SYR**).

NDC Quantity

The NDC Quantity is provided in the HCPCS Units. The numeric quantity administered to the member information is given in Block 24G.

24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS ON UNITS	H. EPST Part 1	I. ID. QUAL	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER							
N415054012002	SOMATULINE DEPOT 120MG/0.5ML			SYR					14	965	09	.5	N	1B	99999
06	29	08	06	29	08	11	J3490						N	NPI	0123456789

Specialty pharmacy providers should refer to the [Specialty Pharmacy Billing](http://www.bcbsfl.com) tips on our website, www.bcbsfl.com, for detailed billing instructions.

Physician Extenders

Registration and Credentialing

BCBSF and Health Options currently define Physician Extenders as advanced registered nurse practitioners (ARNPs), certified nurse midwives (CNMs), clinical nurse specialists (CNSs), physician assistants (PAs), and registered nurse first assistants (RNFAs) who practice independently or as associated members of a physician association. BCBSF may expand this definition in the future to include other provider types.

Physician Extenders, as defined above, are required to obtain a BCBSF provider number, and register their NPI number with BCBSF.

It is the physician's, physician group's, or facility's responsibility to ensure that any employed or contracted Physician Extender is properly licensed and supervised as defined in Florida Statutes 458.347 (1) (f) and 464.012, respectively. They are also responsible for ensuring that employed Physician Extenders maintain proper licenses and credentials. Additionally they must ensure that each Physician Extender is registered with BCBSF.

Claim Submission Requirements

Physician Extender services should be billed with the extender's NPI or BCBSF number in block 24J on the CMS-1500 as the rendering provider.

BCBSF requires a separate claim for each rendering provider. A single service rendered by two or more providers for the same member on the same date of service must be billed with the provider who performed the substantive portion of the service in block 24J. Illustrative examples are listed below:

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

Physician Extenders should not submit claims under the following circumstances:

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

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

Payment for Covered Services

Where contractual language allows, covered services rendered by Physician Extenders not directly contracted with BCBSF will be reimbursed at 85 percent of the contracted provider's rate where a Relative Value Unit (RVU) exists. Physician Extenders directly contracted with BCBSF will be reimbursed at the contracted rate.

Surgical first assist services by a licensed Physician Extender should be billed by the employing physician, group, employer or clinic with the addition of modifier AS and the Physician Extender NPI or BCBSF provider number entered in block 24J as the rendering provider. BCBSF will reimburse these services at 20 percent of the allowed amount when the service is covered and the surgery warrants a surgical assistant.

In-Office Laboratory Services

Only the laboratory (“lab”) services listed below are eligible for payment when performed in the office by a participating BCBSF or Health Options physician. Other lab services performed in the office will be denied for payment (except for PPC and Traditional/PPS physicians rendering services to BlueChoice and Traditional members) and the member may not be billed. Refer other lab services to a participating independent clinical lab (see Independent Clinical Laboratory Services in the [Participation Programs and Responsibilities](#) section).

Codes	Descriptors
36415*	Collection of venous blood by venipuncture
80048	Basic metabolic panel
80051	Electrolyte panel (CO ₂ , Cl, K, Na)
80076	Hepatic function panel (7)
81000	Urinalysis, by dip stick or tablet reagent, non-automated with microscopy
81001	Urinalysis, by dip stick or tablet reagent, automated with microscopy
81002	Urinalysis, by dip stick or tablet reagent, non-automated without microscopy
81003	Urinalysis, by dip stick or tablet reagent, automated without microscopy
81005	Urinalysis, qualitative or semiquantitative, except immunoassays
81015	Urinalysis; microscopic only
81025	Urine pregnancy test, by visual color comparison methods
82150	Amylase
82247	Bilirubin; total
82270	Blood occult, by peroxidase activity (e.g., guaiac), qualitative; feces, 1-3 simultaneous determinations
82272	Blood occult, by peroxidase activity (e.g., guaiac), qualitative; feces, single specimen (e.g., from digital rectal exam)
82565	Creatinine; blood
82803	Gases, blood, any combination of pH, pCO ₂ , pO ₂ , CO ₂ , HCO ₃ (including calculated O ₂ saturation)
82946	Glucagon tolerance test
82947	Glucose; quantitative, blood (except reagent strip)
82948	Blood, reagent strip
83036	Hemoglobin; glycosylated (A1C)
84703	Beta hCG, qualitative
85013	Spun microhematocrit
85014	Hematocrit (Hct)
85018	Hemoglobin (Hgb)
85025	Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85060	Blood smear, peripheral, interpretation by physician with written report
85097	Bone marrow, smear interpretation
85610	Prothrombin time
86308	Heterophile antibodies; screening
86580	Skin test, Tuberculosis, intradermal
87210	Wet mount for infection agents (e.g., saline, India ink, KOH preps)
87220	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (e.g., scabies)
87400	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Influenza A or B, each
87420	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; respiratory syncytial virus
87425	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative,

	multiple step method; rotavirus
87430	Infectious agent antigen detection by enzyme immunoassay technique, Streptococcus, group A
87804	Infectious agent detection by immunoassay with direct optical observation; influenza
87807	RSV assay w/ optic
87880	Infectious agent detection by immunoassay with direct optical observation; Streptococcus, group A
89051	Cell count, miscellaneous body fluids, except blood; with differential count
89060	Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)
89190	Nasal smear for eosinophils
89300	Semen analysis; presence and/or motility of sperm including Huhner test

*Draw fees are only eligible for payment when lab services are sent to an outside laboratory.

- If you perform some lab services in the office and send others to an independent laboratory on the same day of service, add a modifier 90 to code 36415.
- The draw fee is not eligible for separate reimbursement for lab tests performed in the office; it is included in the allowance for the lab service(s).

When billing a lab panel code, if a component lab is billed on the same date for the same patient it would not be eligible for separate reimbursement. For example, glucose code 82947 is part of the basic metabolic panel code 80048. Therefore, if both codes are billed, the component service 82947 is rebundled into the panel code, 80048.

Site of Service

Based on the CMS methodology, BCBSF will reimburse specific CPT/HCPCS codes based on the site of service where the service is performed. This differential recognizes that physician practice costs are generally lower when services are provided in a facility location. This approach has been used by Medicare for several years and is consistent with standard practices in the health care industry. To determine which services and locations are reimbursed at the facility rate, BCBSF uses the same criteria that are applied by Medicare. To identify the services for which a Site of Service differential applies, you can consult the CMS website at <http://www.cms.hhs.gov/center/physician.asp> or use the [Fee Schedule Request Form](#) on BCBSF's website, www.bcbsfl.com, to request a fee schedule that indicates facility and non-facility allowances for the appropriate services.

Ineligible In-Office Advanced Imaging Radiology Services

The following advanced imaging radiology services categories are ineligible for payment to all BCBSF and Health Options participating physicians (unless otherwise stated within contract) when performed in a physician's office. However, should a member need these services, a prior authorization is required through NIA. NIA guidelines information may be found in the [Utilization Management Programs](#) section.

- CT examination of the abdomen
- CT examination of the pelvis, female
- Nuclear cardiology
- MRI and CT examinations of the brain
- MRI and CT examinations of the spine
- MRI examinations of the lumbar spine
- MRI examinations of the knee
- PET cardiac scan
- PET brain scan
- PET tumor scan

Primary Care Physician – Ineligible In-Office Physical Therapy Services

The following physical therapy services are ineligible for payment to Health Options participating primary care physicians when performed in a physician's office:

Physical Medicine and Rehabilitation: 97001 – 97546.

Procedure Code Edits

BCBSF uses ClaimCheck, an automated procedure code editing software application licensed by the McKesson Corporation, to assist in a consistent claim review process by helping to insure coding meets current coding guidelines and BCBSF's/ focus on medical policies for medicine, surgery, laboratory and pathology, radiology and anesthesiology. Unbundling, fragmentation, upcoding, mutually exclusive procedures, duplicate, obsolete, age and sex edits and/or invalid codes are identified.

ClaimCheck was designed to keep pace with the complex developments in medical technology and increasingly more specific CPT coding requirements. The procedure code edits contained in ClaimCheck are based on a review of CPT guidelines, a review of the CMS guidelines, agreed-upon industry practices and analysis by an extensive clinical consultant network as well as published information from specialty societies. In all instances, however, any BCBSF Medical Coverage Guidelines and the member's Benefits Agreement take precedence over ClaimCheck® determinations.

ClaimCheck is designed to identify and correct situations such as procedure unbundling, mutually exclusive procedures, age and sex discrepancies and fragmentation of incidental procedures. A brief description of these and other similar matters are set forth below.

Patient Billing Impact

The edits contained in ClaimCheck are designed to provide appropriate coding and to assist in processing claims accurately and consistently. The member is not responsible and should not be billed for any procedures for which payment has been denied or reduced by BCBSF as a result of unbundling/rebundling, incidental, mutually exclusive or multiple surgery edits.

Procedure Code Unbundling

Procedure code unbundling is the submission of multiple procedure codes for a group of specific procedures that are components of a single comprehensive CPT code. Procedure unbundling may occur in one of two ways:

1. A professional claim could be submitted that has procedure codes for both the individual components, and the procedure code for the comprehensive procedure. In this instance, the individual component codes will be rebundled into the comprehensive procedure code for payment.

The following message will appear on your remittance advice:

Paper: "Payment included in allowance for another service."

Electronic: "Payment is included in the allowance for another service/procedure."

2. Procedure unbundling could also occur when a professional claim is submitted with only the individual components of the comprehensive code. In this situation, the system editing will recognize the relationship between the comprehensive code and its individual components. Then, it will automatically add the comprehensive code to the claim and rebundle the individual components into that comprehensive code for payment.

The following message will appear on your remittance advice:

Paper: "Payment included in allowance for another service."

Electronic: "Payment is included in the allowance for another service/procedure."

Mutually Exclusive Procedures

Mutually exclusive procedures exist when a claim is submitted with two or more procedure codes that are not usually performed on the same patient, on the same date of service. This includes combinations of procedures that may be anatomically impossible, represent overlapping and / or duplication of services, or are reported as both an initial and subsequent service.

For example, a claim is submitted for a colectomy, total, with continent ileostomy (44151) and a colectomy, partial, with coloproctostomy (44145). Since a total colectomy (or removal of the colon) can only be performed once, payment would not be made for both procedure codes.

The following message will appear on your remittance advice:

Paper: "Payment included in allowance for another service."

Electronic: "Payment is included in the allowance for another service/procedure" and "Service is not payable with other service rendered on the same date."

Incidental Procedures

An incidental procedure is performed at the same time as a more complex primary procedure. However, the incidental procedure is clinically integral to the successful outcome of the primary procedure. For this reason, an incidental procedure will not be reimbursed separately. The system editing will deny procedures that are considered incidental when submitted with related primary procedures on the same date of service. For example, a lab submits a claim for routine venipuncture (36415) with prothrombin time (85610). 36415 is considered incidental to 85610 and therefore would not be reimbursed separately.

The following message will appear on your remittance advice:

Paper: "Payment included in allowance for another service."

Electronic: "Payment is included in the allowance for another service/procedure."

Definition of a Surgical Package

The CPT surgical "package" concept means that surgical procedures include the surgical operation, local infiltration, metacarpal/digital block or topical anesthesia when used, and the typical postoperative follow-up care visits. These services, when billed in addition to the surgery, are denied as included in the surgical allowance. For post-operative follow-up visits, BCBSF uses the follow up days as defined by CMS. Refer to the current year's CPT book for evaluation and management services and surgery guidelines.

The following message will appear on your remittance advice:

Paper: "Payment included in allowance for another service."

Electronic: "Payment is included in the allowance for another service/procedure."

Multiple Surgery Guidelines

The multiple surgery policy applies when a single physician or physicians in the same group practice perform separate procedures on the same patient during the same operative session or on the same day for which separate payment may be allowed. This also applies to lesion removal.

All procedures performed on the same date of service, by the same physician for the same patient should be submitted on one claim.

Codes that are not exempt from multiple surgery guidelines will be reimbursed at 100% of the fee allowance for the most clinically intensive procedure, then at 50% for each additional procedure allowed on the same day. The procedure's Non-Facility Relative Value Unit (RVU) determines clinical intensity.

Procedure codes identified as "modifier –51 exempt" and "add-on" codes are not subject to multiple surgery reductions. A listing of these codes can be found in the current CPT code book under Appendix D (modifier –51 exempt) and Appendix E (add-on).

Medical and Surgical Supplies

Medical and surgical supplies during an outpatient or physician office visit are normally included as incidental to the E/M service (99201-99215). Procedure code 99070 is considered included in any other service performed by the same provider on the same day for the same patient.

Downcoding

BCBSF does not automatically reassign or reduce the code level of evaluation and management codes billed for covered services. BCBSF may, however, deny or reassign a new patient visit code when it is billed inappropriately based upon guidelines for new patient visits found in the current CPT book. BCBSF may also reassign or reduce the code level for selected claims based on a review of clinical information provided that the decision to reassign or reduce is based primarily on a review of clinical information, including review of clinical information derived from BCBSF fraud or abuse billing detection programs.

Periodic Updates

ClaimCheck is updated twice a year to accommodate coding changes. Refer to the [Bulletins](#) section of www.bcbsfl.com for the latest ClaimCheck updates. All claims submitted after the implementation date, regardless of service date, will be processed according to the updated version. No retrospective payment changes/adjustments/request refunds will be made when processing changes are a result of new code editing rules within the ClaimCheck module.

Clear Claim Connection

You can simulate the likely procedure code editing rules for your BCBSF claims prior to submission or after receiving the remittance advice by using Clear Claim Connection; available through the Availity Health Information Network.

This tool is intended for use as a simulation for general information and is not binding on BCBSF. Medical Coverage Guidelines, member benefits, terms, limitations and exclusions will override any prepayment edit.

Claims are adjudicated using the 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 BCBSF claims. Medicare Supplement and Medicare Advantage Private Fee-for-Service claims are not subject to the procedure code editing rules displayed by Clear Claim Connection.

How to Use Clear Claim Connection

From Availity's 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 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
- 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, then click the *Review Clinical Edit Clarification* button. Or, just 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.

Electronic Claims Submission

Electronic claims must be filed through the Availity Health Information Network. You may access the Availity Health Information Network directly or send your claims through a billing service or clearinghouse to transmit to Availity; Availity will then route to BCBSF. For more information, refer to the [Electronic Self-Service Tools](#) section. For questions about Availity, call **(800) AVAILITY (282-4548)** or to register, visit www.availity.com.

National Provider Identifier

As of May 23, 2008, all health care providers are required to submit a standard unique National Provider Identifier (NPI) on all electronic transactions. This number replaces all other provider numbers and identifiers (e.g., UPIN, Medicare, BCBSF number). For additional information on NPI, refer to the [CMS website](#).

For information on obtaining a NPI, refer to the NPPES website at www.nppes.cms.hhs.gov. Before using your NPI to file claims, you must register it with BCBSF. Simply complete and return the [National Provider Identifier \(NPI\) Notification Form](#), available on our website, www.bcbsfl.com.

Paper Claims Submission

Filing your claims electronically is both quicker and more cost effective. However, there may be times when it is necessary to file paper claims. The CMS-1500 (or equivalent) and the UB-04 are the claim forms accepted by BCBSF.

CMS-1500

The National Uniform Claim Committee (NUCC) determines the data elements and design of the CMS-1500. For additional information, including instructions on completing the form, refer to www.nucc.org.

UB-04

The National Uniform Billing Committee (NUBC) and the Florida State Uniform Billing Committee (SUBC) determine the data elements and design of the UB-04. These data elements are published in the National Uniform Billing Data Element Specifications Manual, which contains instructions for completing the UB-04 claim form.

If you would like to enroll in the UB-04 subscription service to receive a complete UB-04 manual and updates, visit www.nubc.org. You may also contact the Florida Hospital Association Management Corporation at www.fha.org or **(407) 841-6230**.

Optical Character Recognition (OCR)

BCBSF uses OCR scanning equipment to process paper claims. OCR is an automated system that reads and interprets the characters in each block submitted on the claim form. The information is then sent into the claims processing system. The more accurately the claim is completed, the less manual intervention is necessary.

The following guidelines will help in preparing paper claims for OCR scanning:

- **Form:** Print the claim information in black ink on a blank, red ink CMS-1500 or UB-04 form. You may also use software programs, which print both the form and the claim information in black ink. Do not fold, staple or tape your claim.
- **Alignment:** Align all information within the designated field.
- **Font:** Use upper case letters in Courier font, size 10 (CMS-1500) or size 12 (UB-04). Do not bold or italicize font.
- **Characters:** Do not use special characters (e.g., dollar signs, decimals, dashes, zeros or sevens with slashes).
- **Names:** Omit any titles, such as “Mr.” or “Mrs.” Enter the last name first, followed by a comma, then the first name.
- **Dates:** Use an eight-digit format for dates and do not space between numbers (e.g., enter June 15, 2008 as 06152008).
- **Time:** Use a four-digit format for time, referred to as “units” in block 24G (e.g., enter 1 hour 30 minutes as 0130).

Rejected Claims

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

Medical Records

Under certain circumstances, BCBSF will require routine clinical information or medical records for select procedures/situations. Providers must submit the necessary clinical information with the initial claim. Failure to submit the needed records may result in processing and payment delays.

Clinical documentation may include, but is not limited to, the following:

- Operative reports
- Physician/nurse notes
- Lab results
- Radiology reports
- Anesthesia notes and time
- Plan of treatment

Claim Filing Addresses

Submit paper claims to the following address (for exceptions, see Dedicated Service Units):

Blue Cross and Blue Shield of Florida
P.O. Box 1798
Jacksonville, FL 32231-0014

Dedicated Service Units

Send claims and correspondence for the following groups and product lines to the addresses below.

Atlantic, Quebec & Ontario Blue Cross (Canadian Travel Insurance)

Blue Cross and Blue Shield of Florida
P.O. Box 45149
Jacksonville, FL 32232-5149

State Employees' PPO Plan

Blue Cross and Blue Shield of Florida
P.O. Box 2896
Jacksonville, FL 32232-0079

Medicare Supplement

Blue Cross and Blue Shield of Florida
P.O. Box 44160
Jacksonville, FL 32231-4160

Medicare Advantage (HMO and PPO) Claim and Encounter Data Reporting

The Medicare Advantage program requires Medicare Advantage Organizations to submit all encounter/claim data to CMS for the purpose of risk adjustment payments. Encounter/claim data is all data necessary to characterize the context and purpose of each encounter between a Medicare Advantage member and the provider. The encounter/claim data will be used by CMS to determine the risk status of the population enrolled in each Medicare Advantage Organization and modify its payment to the Medicare Advantage organization accordingly.

Provider Requirements

All participating providers are required to provide encounter/claim data for all services rendered to Medicare Advantage members within 30 days of the service date, unless contractual provisions have been made to extend this time frame. This includes both inpatient and outpatient services.

Providers agree to:

- Give BCBSF and its authorized designees the right to audit, evaluate, and inspect all books, contracts, medical records, patient care documentation, and other provider and contractor/subcontractor records relating to care for a Medicare Advantage member. This includes any aspect of services provided to Medicare Advantage member for a period of 10 years following the service date, or until completion of an audit, whichever is later, unless such timeframe is extended pursuant to federal law.
- Cooperate and furnish any needed information to BCBSF that is required for submission of risk adjustment data on Medicare Advantage members and provide clinical records containing member information in order for BCBSF to provide complete and accurate submission of risk adjustment data to CMS.

- Provide records to BCBSF and CMS that may be required for advance coverage determinations, determinations of coverage and medical necessity of services, support of billing for claims submitted to BCBSF, and for any audits required by laws including for audits for fraud and abuse.

Providers must manually sign electronic medical records or include the statement “Electronically Signed.” CMS does not accept records not signed by the provider. A medical record that lacks a date of service or physician signature and credentials is considered invalid and unacceptable by CMS.

All encounter/claim data submitted to BCBSF must be truthful, accurate, and complete. Providers may be requested, annually, to certify that encounter/claim data submitted to BCBSF is accurate, complete, and truthful to the best of their knowledge and belief. If the provider knows that not all encounter data has been sent to BCBSF, or that the data may have integrity problems, the provider must notify BCBSF immediately.

Data Requirements

Providers must either submit a CMS-1500 (or equivalent) or UB-04 paper claim form with all the information that is required for original Medicare submission or file the required data electronically. Failure to complete all required information could result in the claim rejecting, payment delays, and/or additional development requests. Following are data requirements:

CMS-1500:

- Patient’s name (block 2)
- Insured’s name (block 4)
- Member ID number (block 1a)
- Patient relationship to member (block 6)
- Patient date of birth (block 3)
- Date of service (block 24A)
- CPT procedure codes with modifiers when appropriate (block 24D)
- ICD diagnosis code(s) to highest level of specificity (block 21)
- Place of service (block 24B)
- Unit(s) of service (block 24G)
- Charge(s) (block 24F)
- Performing provider’s individual number or professional association (PA) NPI, if applicable (block 24J)
- Federal Tax ID number (block 25)
- Provider of service signature (block 31)
- Billing provider’s information and phone (block 33)
- Billing provider’s NPI, if applicable (block 33a)
- Billing provider’s other ID number (i.e., BCBSF provider number), if applicable (block 33b)

UB-04:

- Provider name (field 1)
- Type of bill (field 4)
- Federal Tax ID number (field 5)
- Statement covers period (field 6)
- Patient name (field 8)
- Patient address (field 9)
- Patient birth date (field 10)
- Patient sex (field 11)
- Admission date (field 12)
- Admission hour (field 13)
- Type of admission (field 14)
- Source of admission (field 15)
- Discharge hour (field 16)
- Patient status (field 17)
- Revenue code (field 42)
- Payer name (field 50)
- Health plan ID (field 51)
- Insured’s name (field 58)
- Patient’s relationship (field 59)
- Insured’s unique ID (field 60)
- Principal diagnosis code and POA indicator (field 67)
- Other diagnosis codes (field 67A-Q)
- Admitting diagnosis (field 69)
- Attending NPI/QUAL/ID/Last/First (field 76)

Medicare Supplement Claims

Medicare Supplement claims should be filed initially to Medicare with BCBSF indicated as the supplemental carrier. Medicare will usually automatically crossover claims to BCBSF for any applicable deductible and coinsurance amounts. Claim information will not be crossed over to BCBSF until after Medicare has processed the claim and released it from the Medicare payment hold.

After receipt of the Medicare Remittance Notice, review the indicators to identify whether the claim was crossed over directly to BCBSF.

- If the indicator shows the claim crossed over, Medicare has submitted the claim to BCBSF and the claim is in progress. You do not need to take further action. The 835 (electronic remittance) record can also carry the secondary forwarding information.
 - You will receive payment or processing information from BCBSF after we receive the Medicare payment. Please allow 45 days from the primary payment date for the processing of the secondary claim.
- If the claim did not crossover automatically, then file the claim to BCBSF with the Medicare Remittance Notice attached. It is important that you allow 45 days after you receive the Medicare Remittance Notice before filing the Medicare Supplement insurance coverage claim.

Participating Medicare Select providers have agreed to accept the Medicare allowed amount as payment-in-full for covered services.

Claim Documentation Requests

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

The following are tips for submitting claim documentation when it is requested:

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

Helpful Claims Filing Hints

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

- **Verify coverage.** Groups often have changes in their health insurance benefit plans. Make re-verifying coverage through the Availity Health Information Network or the telephone self-service option a routine part of your practice.
- **Submit the entire member ID number including alpha prefix.** Submit the member ID number not the member's Social Security number. Remember to correct your billing system when there are changes.
- **Complete all claim entry fields.** To receive proper reimbursement, the claim information must be completed in its entirety. Incomplete or inaccurate information will result in a claim denial.
- **Enter the date of onset, if applicable.** All ICD diagnosis codes in the 800-900 range require a date of onset (injury, accident, first symptom, etc.).
- **Use valid codes.** CPT, HCPCS, and ICD codes are updated quarterly. Make sure you or your billing service is using the most up-to-date codes.
- **Report an unlisted code only if unable to find a procedure code that closely relates to or accurately describes the service performed.** Unlisted codes require documentation and therefore cannot be submitted electronically.
- **Use diagnosis codes that indicate a general medical exam when billing for “preventive” health screening exams.** Claims for these services will be denied if other diagnosis codes are used.
- **Submit modifiers affecting reimbursement in the first and second position on claims.** A procedure code modifier, when applicable, provides important additional information about the service performed.
- **Submit multiple procedures on one claim.** All procedures performed on the same date of service, by the same provider for the same patient should be submitted on one claim.
- **Submit all applicable diagnosis codes.** Code to the highest level of specificity possible. Most 3-digit codes require a fourth or fifth digit.
- **Include the NPI for rendering physician and billing physician or group.** Both the CMS-1500 and UB-04 include fields for the NPI.

CMS-1500:

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

The above blocks are split to allow your BCBSF provider number in the shaded area and your NPI in the unshaded area labeled NPI.

UB-04:

- Field 56 is for the NPI of the Billing Facility/Provider
 - Field 76 is for Type 1 NPIs (Attending Provider)
 - Fields 78 and 79 are for Type 1 NPIs (Other Referring Provider)
- **Use the correct Tax ID or Social Security number.** For participating providers, the Tax ID number reported on the claim should match the Tax ID number found within the provider agreement, which is the provider/legal entity's payee Tax ID number. Should your legal entity Tax ID change, please contact your BCBSF Network Manager directly before claims are submitted containing this new information.
 - **If services are rendered in other than home or office, enter the complete name and address of the facility where services were performed.** Include the NPI of the facility, if available.
 - **Submit the correct billing provider information.**
 - Individual Physicians/Providers: Enter the name, address, phone number, and NPI of the individual physician, if services were rendered in a solo practice.
 - Groups: Enter the name, address, phone number and NPI of the group practice.
 - **Avoid sending duplicate claims.** For claims status, use Availity or call (800) 727-2227. If filing electronically, be sure to also check your Availity file acknowledgement and EBR for claim level failures. Allow 15 days for electronic claims and 30 days for paper claims before resubmitting.
 - **If you do not submit your corrected claims electronically, then indicate “Additional Services” on claims when billing for additions to the original claim.** This will clearly distinguish your claim as being filed in addition to the original, but not replacing the original claim (i.e., a corrected claim). The additional services must be submitted on a paper claim form.

Timely Filing

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

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

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

Claim Inquiries

Providers may submit inquiries on claims for a variety of reasons (e.g., corrected claims, late charges, medical records, etc.). When submitting a claim inquiry, complete the [Provider Claim Inquiry Form](#) available on our website, www.bcbsfl.com, and attach it to your claim.

Corrected Claims

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

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

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

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.
- Attach the completed Provider Claim Inquiry Form with your corrected claim.

When submitting an **electronic** corrected claim through the Availity Health Information Network, use the Bill and Frequency Type codes listed below.

- **7 – Replacement of Prior Claim**

If you have omitted charges or changed claim information (diagnosis codes, dates of service, member information, etc.), resubmit the entire claim, including all previous information and any corrected or additional information. Hospitals and facilities should include the seven in the third digit of the Bill Type. Physicians should submit with a Frequency Type code of seven.

- **8 – Void/Cancel of Prior Claim**

If you have submitted a claim to BCBSF in error, resubmit the entire claim. Hospitals and facilities should include the eight in the third digit of the Bill Type. Providers should submit with a Frequency Type code of eight. If the claim was paid, resubmit the claim to BCBSF via paper and attach a check for the amount that was paid in error.

Claim Status

Obtain claim status information on BCBSF members through the Availity Health Information Network (see the [Electronic Self-Service Tools](#) section) or the self-service telephone option at **(800) 727-2227**; simply say “Claim Status” when prompted.

Provider Appeals

Providers may request reconsideration of how a claim processed, paid or denied. These requests are referred to as appeals.

There are four different types of appeals:

- Coding and Payment Rule Appeals
- Utilization Management Appeals
- Adverse Determination Appeals
- All Others

If there is a reduction in payment or a denial of your claim, the remittance advice will provide an explanation as to the reason for the reduction or denial of the claim.

Participating providers must submit appeals within one year of the date that appears on the respective remittance advice. BCBSF will not overturn administrative claim denials based on the provider's failure to comply with required procedures and time frames.

Providers may not balance bill members for covered services; including disputed amounts. You may bill members for applicable deductible, coinsurance and/or copayment and non-covered amounts per your specific Agreement.

If an appeal is approved, the claim is forwarded for adjustment and/or payment. If an appeal is denied, a letter is sent informing you of the denial.

Each appeal type is described in detail below.

Coding and Payment Rule Appeals

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 BCBSF's application of its coding and payment rules and methodologies (including without limitation any bundling, downcoding, application of a CPT modifier, and/or other reassignment of a code by BCBSF). These appeals apply to claims filed by M.D.s and D.O.s in connection with health care services rendered to a specific individual covered under a policy or plan insured or administered by BCBSF. A Coding and Payment Rule Appeal does not refer to pre-service review, concurrent review, claim status requests, and other types of provider communication, such as telephone inquiries.

Claims processed after the implementation date, 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 an exception to the rule above applies or, a physician is appealing a case specific exception, the appeal should be sent to the address below with the following information:

- The completed [Provider Appeal Form](#) (available at www.bcbsfl.com).
- 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.

If a physician disagrees with BCBSF's edit logic overall (not case-specific), provide a written statement of the appeal, along with the following information:

- The completed Provider Appeal Form.
- Documentation normally required for a medical review.
- Written explanation supporting the procedure codes submitted.
- Documentation from a recognized authoritative source that supports your position on the procedure codes submitted (optional).

Send Coding and Payment Rule Appeals to:

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

Billing Dispute External Review Process

The Billing Dispute External Review Process (BDERP) will provide for a Billing Dispute External Reviewer (BDER), to resolve disputes with physicians and physician groups arising from covered services provided to BCBSF's members by such physicians and/or physician groups concerning:

- For Coding and Payment Rule appeals finally adjudicated on or after August 21, 2008, BCBSF's application of BCBSF's coding and payment rules and methodologies for covered fee for service claims (including any bundling, downcoding, application of a CPT modifier, and/or other reassignment of a code by BCBSF) to patient specific factual situations, including without limitation the appropriate payment when two or more CPT codes are billed together, or whether a payment enhancing modifier is appropriate. All such Billing Disputes must be submitted to the BDER no more than 90 calendar days after a physician or physician group exhausts the internal appeal process, except the parties have agreed that for appeals finally adjudicated after August 21, 2008 and before November 21, 2008, the date the BDERP will start accepting claims, the physicians and physician groups will have until December 20, 2008 to submit their eligible billing disputes. For calculation purposes, the start date will be the date on the appeal letter and the ending date will be when a Billing Dispute is received by the BDER. This will determine if the 90 calendar day requirement is met; or
- The BDER will not have jurisdiction over any other disputes, including disputes that fall within the scope of the Independent Review process within the Love (formerly Thomas) Settlement Agreement, Compliance Disputes and disputes concerning the scope of covered services. Also, the BDER will not have jurisdiction or authority to revise or establish any BCBSF reimbursement policy.

Other requirements:

- A physician or physician group must submit all documentation reasonably needed to decide the internal appeal to BCBSF's Provider Appeal and Dispute Department. A physician or physician group will be deemed to have exhausted BCBSF's internal appeal process, if BCBSF does not communicate a decision on an internal appeal within 30 calendar days of BCBSF's Provider Disputes Department receipt of all documentation reasonably needed to decide the internal appeal.
- The amount in dispute by the physician or physician group must exceed \$500.00. A physician or physician group may submit multiple Billing Disputes with an amount in dispute less than \$500.00; if the physician or physician group notifies the BDER that the physician or physician group intends to submit additional Billing Disputes during the one (1) year period following the submission of the original Billing Dispute, which involves issues that are similar to those of the original Billing Dispute.

- Only Medical Doctors, Doctors of Osteopathy, and their physician groups may file Billing Disputes. No other provider type (e.g., Doctor of Chiropractic Medicine, Doctor of Podiatry, etc.) may file a Billing Dispute.
- The BDER process is not available to a physician or physician group when the member has a Federal Employee Health Benefit Agreement.
- BCBSF's contract with the organization selected to serve as a BDER will require decisions to be rendered not later than 30 calendar days after receipt of the documents necessary for the review and to provide notice of the decisions to BCBSF and physician(s) or physician group(s).
- In the event that the BDER issues a decision requiring payment by BCBSF, BCBSF will make the payment within 15 calendar days after receiving the decision notice.

Contact MES Solutions for all Billing Dispute External Review process inquiries:

MES Solutions
 Attn: BDRP Dept
 100 Morse St
 Norwood, MA 02062

Phone: (800) 437-8583
 Fax: (888) 869-2087
 Website: www.mesgroup.com

Utilization Management Appeals

A Utilization Management (UM) Appeal is defined as a written request from a provider to review a claim that required an authorization 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 BCBSF or within five years from payment date. BCBSF 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 Appeal Form](#) (available at www.bcbsfl.com).
- A copy of the remittance advice.
- 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:

Blue Cross and Blue Shield of Florida
 Provider Disputes Department
 P.O. Box 43237
 Jacksonville, FL 32203-3237

Note: For information on the appeal of **pre-service and concurrent review decisions** refer to the [Utilization Management Programs](#) section.

Adverse Determination Appeals

A provider may file a written request with BCBSF for reconsideration of a denial of payment because a proposed, or actual, health care service or supply was not medically necessary or was experimental or investigational (“Adverse Determination Appeal”). An Adverse Determination Appeal can be of pre-service claims or a 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.

Pre-Service Adverse Determination Appeals

A physician (i.e., Medical Doctor or Doctor of Osteopathy) or physician group can appeal a pre-service Adverse Determination (Pre-Service Appeals), if they are appealing on behalf of a BCBSF member. Except for urgent Pre-Service Appeals, authorization must be obtained from the BCBSF member in writing. Pre-Service appeals will be handled by BCBSF 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.

Post-Service Appeals

A provider can appeal a post-service Adverse Determination (Post-Service Appeal). An Adverse Determination Post-Service Appeal must be submitted in writing within one year of date of payment and sent to the address below with the following information:

- The completed [Provider Appeal Form](#) (available at www.bcbsfl.com).
- 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 an internal Post-Service Appeal of any denied service or supply if:

- BCBSF’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
- BCBSF’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 both BCBSF’s member (or his or her representative) and the provider or provider group seek review of the same denied service, BCBSF’s member appeal shall go forward and the provider or provider group appeal will be dismissed.

Send Adverse Determination internal appeals to:

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

Adverse Determination External Review Process

The Adverse Determination External Review process will provide for an Independent Review Organization (IRO), to resolve disputes with physicians and physician groups arising from BCBSF's determination that certain services provided to BCBSF's members are not covered services because they are not medically necessary or experimental or investigational in nature ("Adverse Determination Disputes"). The external review process is only available if BCBSF makes the Adverse Determination and administers its Plan Member appeals and/or external review process. Additionally, the Adverse Determination External Review Process is only available if BCBSF upholds its initial Adverse Determination through the internal Post-Service Appeals process and the cost of the service at issue exceeds the threshold amount, if any, the BCBSF's Plan member would need to satisfy in order to seek external review under the terms of the applicable health benefit plan.

The physician or physician group may file an Adverse Determination Dispute with the IRO, if BCBSF upholds its initial Adverse Determination through the internal Adverse Determination Appeals process and the following requirements are met:

- Only Medical Doctors, Doctors of Osteopathy, and their physician groups may file an Adverse Determination Dispute. No other provider type (e.g., Doctor of Chiropractic Medicine, Doctor of Podiatry, etc.) may file an Adverse Determination Dispute.
- A pre-requisite to participate in the Adverse Determination Dispute process is to complete the Adverse Determination Appeals process.
- BCBSF must have issued its denial decision of the Adverse Determination Appeal on or after April 21, 2009.
- To be considered by the IRO, a Physician or Physician Group must submit a written request for external review (i.e., Adverse Determination Dispute) to the IRO within sixty (60) calendar days from the date of the internal Adverse Determination Appeal denial decision by BCBSF with the appropriate fee.

BCBSF's contract with the IRO requires decisions to be rendered not later than 30 calendar days after receipt of the documents necessary for the review and to provide notice of the decisions to BCBSF and physician(s) or physician group(s). The IRO's external reviewer shall be of the same specialty (but not necessarily the same sub-specialty), as the appealing physician.

The physician or physician group may not initiate an Adverse Determination Dispute of any denied service if:

- BCBSF's member is covered under a Self-Insured Plan and the Plan sponsor has not agreed by contract to participate in the Adverse Determination Dispute process
- BCBSF's member is covered by a Federal Employee Health Benefit Agreement.

Contact MES Solutions, the IRO for BCBSF, for all Adverse Determination Dispute process inquiries:

MES Solutions
Attn: Love Settlement Dept
100 Morse St
Norwood, MA 02062

Phone: (800) 437-8583
Fax: (888) 868-2087
Website: www.mesgroup.com

All Other Appeals

If an appeal does not fit into any of the three categories listed above, it is considered an appeal type of "Other." Examples 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

Appeals should be sent to the address below with the following information:

- The completed [Provider Appeal Form](#) (available at www.bcbsfl.com).
- 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.

Send appeals (excluding HMO behavioral health appeals) to:

Blue Cross and Blue Shield of Florida
P.O. Box 1798
Jacksonville, FL 32231

HMO Behavioral Health Appeals

All HMO behavioral health appeals are coordinated through MHNet. Send appeals to:

MHNet
Appeals Department
1211 State Road 436
Casselberry, FL 32707

Statewide Provider and Health Plan Claim Dispute Resolution Program

If providers submit a claim dispute eligible under this statutory program to the resolution organization, they should also provide a copy to BCBSF at:

Blue Cross and Blue Shield of Florida
Provider Disputes Department
4800 Deerwood Campus Parkway, Bldg. 900
Jacksonville, FL 32246

This address should not be used to submit other types of appeals or correspondence to BCBSF.

Coordination of Benefits

Coordination of benefits (COB) refers to two or more insurance plans covering one individual, coordinating their respective benefits to share the cost of health care. COB rules identify one plan as the primary payer (this plan pays regular contract benefits first) and the other plan as secondary (this plan pays the balance of charges up to the limits of its contract, but never more than what it would have paid if primary).

It is the member's responsibility to provide other insurance information to BCBSF annually. A form is mailed to the member to complete and return. Many of our members may also update their other insurance information directly online. Providers can access the [Other Insurance Information Form](#) on our website, www.bcbsfl.com 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

Following are steps to determine what payments are due when a member has two insurance carriers.

1. **Verify the 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.
2. **File the claim to the primary insurance carrier.** Include all other insurance carrier information in the appropriate COB fields of the electronic form, blocks 9a-d of the CMS-1500 or fields 50A-C of the UB-04 claim form.
3. **File the claim to the secondary insurance carrier.** If BCBSF is the secondary carrier, file the claim to BCBSF on the member's behalf, once the primary insurance has completed processing. Include all other insurance carrier information in the appropriate COB fields of the electronic form, or blocks 9a-d of the CMS-1500 or fields 50A-C of the UB-04 claim form and attach a copy of the other carrier's remittance advice.
4. **Collect the BCBSF deductible, coinsurance, copayment and/or non-covered services amounts.** The terms of your Agreement apply whether the member's BCBSF policy is primary or secondary. Deductibles and coinsurance amounts should be based on the lower of the BCBSF allowance or the provider's charge. BCBSF's payment when added to other payments shall not exceed 100 percent of the amount agreed to be paid for the services under the applicable BCBSF provider agreement. Do not balance bill the member. It is recommended that you wait to collect the coinsurance amount from the member until payments from both insurance companies have been received, which will alleviate the need to issue refunds.

COB General Rules

COB rules may vary by contract and the rules below do not cover every situation.

Contract Holder/Spouse

1. The plan without a COB provision pays before a plan with a COB provision.

Dependent/Non Dependent Rule

2. The benefits of a plan which covers the person as an employee, retired employee, member or subscriber (other than a dependent) are primary to a plan covering a person as a dependent member, EXCEPT;
 - a) If the person has Medicare Part A coverage; and
 - b) Is entitled to benefits as a dependent of an active worker; and
 - c) The Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as the dependent,
 - d) The order is:
 1. Plan of the active worker covering the person as a dependent;
 2. Medicare;
 3. Plan covering the person as an employee, member or subscriber other than through active employment (e.g., retiree policy).

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.

Active/Inactive Rule

3. 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 rule #2.)

Dependent Children

4. If the member is a dependent child, submit to the parent's plan whose birth date, based on month and day, falls earliest in the year, disregarding the year of birth. 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.
5. 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. If not stated in the decree, submit bills in the following order:
 - 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

Default Rules

6. If one plan is a Florida plan and the other is an out-of-state plan and the rules do not agree, follow the rules of the out-of-state plan.
7. If none of the above rules determine the primary plan, the contract with the earliest effective date is primary.

COB with Medicare for Group Plans

There are special rules that apply to coordination of benefits with Medicare for group plans. The group plan often pays primary in cases where the member's group coverage is based on his/her own active employment or the active employment of a spouse or parent or where the member has Medicare due to disability or end-stage renal disease (ESRD).

Special rules may apply to members who have group health insurance and Medicare. In many cases, group insurance will pay before Medicare. Following are some, but not all, instances where group insurance would pay before Medicare:

Working Aged

If the employee, or the 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, who are entitled to Medicare due to a disability other than ESRD, who 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 must have their group coverage as the primary payer and Medicare as the secondary payer.

End-Stage Renal Disease (ESRD)

Employees or their dependents, who 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 and Medicare as the secondary payer for the first thirty months of entitlement to Medicare. Thereafter, Medicare will be primary and their group coverage will be secondary.

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 (i.e., persons entitled due to disability whose employer has less than 100 employees or retirees over the age of 65). Also, 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 - No Fault Auto, Workers' Compensation and Subrogation

No Fault Auto Insurance

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. BCBSF would pay as primary until the Personal Injury Protection (PIP) deductible has been satisfied. The auto carrier would then assume the responsibility of the primary payer up to policy limits.

If the auto carrier denies payment due to an exclusion under its contract, the notice of the rejected claim must be submitted with claims to BCBSF. An injured party may elect to reserve PIP coverage for lost wages. Notice of the reservation must be submitted with claims to BCBSF. A participating provider may not elect to withhold claims for members with BCBSF insurance coverage in favor of collecting from settlement proceeds from an injury where there is third party liability. To do so constitutes balance billing which is a breach of contract for participating providers.

Workers' Compensation

Workers' Compensation is designed to provide cash and medical care benefits for workers who sustain injuries or illness arising out of, or in the course of, employment. The Workers' Compensation exclusion clause, in BCBSF's insurance contracts, is intended to exclude payment of benefits when a member or dependent is entitled to benefits under the Workers' Compensation law.

Work-related injuries must be billed to the Workers' Compensation carrier. According to Florida law, payment from a Workers' Compensation carrier is considered as payment-in-full. Therefore, benefits would not be coordinated for work-related illnesses or injuries. If the health care insurer makes payment in error, it is entitled to seek full restitution. If the Workers' Compensation carrier has denied payment, a copy of the denial should be submitted to BCBSF with the claim.

Coordination of benefits for work-related illnesses or injuries may occur on an exception basis. These exceptions would be determined based upon BCBSF's contract language or, in the case of coverage issued by another Blue Plan, on the provisions of that Plan's contract. In the event an exception exists, then BCBSF would always be the secondary insurance. A copy of the Workers' Compensation remittance should be submitted with the claim.

Benefits are not available under BCBSF contracts for work-related injuries to individuals who elect exemption from Workers' Compensation coverage or who waive entitlement to Workers' Compensation benefits.

Subrogation

Under a subrogation contract provision, BCBSF has the right to "stand" in the shoes of the insured against a "wrongdoer." Subrogation typically occurs when one party is injured as a result of the actions or negligence of another. Examples include: slip and fall accidents, assault, and frequently, auto accidents where subrogation applies. In the event that BCBSF makes any payment to or on behalf of an insured for any claim in connection with or arising from a condition resulting directly or indirectly from an intentional act or from the negligence or fault of any third party or entity, BCBSF will exercise its subrogation rights to recover the cost of the medical expenses, regardless of whether litigation is initiated. Subrogation recoveries may not be claimed by a participating physician or other health care provider in lieu of, or in addition to, making a claim for payment pursuant to the terms and provisions of your Agreement when a member has BCBSF insurance. To do so constitutes balance billing, which is a breach of contract for participating physicians and providers.

COB Overpayments

For questions regarding overpayments as a result of coordination of benefits call the Provider Contact Center at **(800) 727-2227** prior to refunding money to the member. Providers must promptly refund overpayments made by BCBSF. Refer to the [Overpayment Recovery and Audit](#) section for additional information.

Remittance Advice

The remittance advice provides you with claim payment and reject information. When you file a claim, you will receive a paper remittance advice. If a payment is due, the BCBSF check is attached or you may receive your monies due via Electronic Funds Transfer (EFT). Claims are processed daily, but only one remittance advice and one payment is generated weekly. Our remittance cycles occur according to the zip code grouping of the payee's address. Capitation is paid once a month (by the 15th of the month). These dates are subject to change.

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

- PPO/Traditional (including BlueCard)
- Federal Employee Program (FEP Basic and Standard)
- State Employees' PPO Plan
- Health Options
- Various Administrative Services Only accounts

If you file electronically, you can receive the 835 Electronic Remittance Advice per request. Refer to the [Electronic Self-Service Tools](#) section for additional information on how to start receiving the 835.

Electronic Funds Transfer

Providers may choose to receive select claim payments by electronic funds transfer (EFT). EFT enables you to receive claim payments directly deposited into your bank account. An average EFT transaction is faster than transferring funds by check.

To sign up for direct deposit payments through EFT, complete the [Electronic Funds Transfer Registration Form](#) available on our website, www.bcbsfl.com. Attach an original voided check or original letter (no photocopies) from your financial institution and mail to the address indicated on the form. Once the form has been received, your EFT request will be processed within 24 hours. You will receive written notification that your application has been processed and completed.