PROVIDER CONNECTIONS

Prestige HEALTH CHOICE®
Leading the Way to Quality Care

2020 **ISSUE 2**

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A Provider's Link to Prestige Health Choice

For current information on the coronavirus (COVID-19), please visit our website at **www.prestigehealthchoice.com.**

Healthy Behaviors programs

Prestige Health Choice offers Healthy Behaviors programs for eligible members to earn rewards for reaching certain health milestones. Members can earn up to a $50 reward per program. There is no limit on how many programs members can complete as long as they qualify. For a complete list of Healthy Behaviors programs and associated forms, please visit **www.prestigehealthchoice.com**.

How our **Utilization Management** program works for providers

The Prestige Health Choice Utilization Management (UM) staff (i.e., nurses, Medical Directors, and pharmacists) regularly reviews the medical appropriateness of services for which authorization is requested. Approval or denial of coverage for requested services is based on medical necessity, eligibility for outpatient and inpatient services, and benefit guidelines. The medical necessity review is performed using:

- Nationally accepted and state-specific medical guidelines.
- Medical information, including Medicaid benefits and supporting clinical information.

Prestige Health Choice does not reward health care providers for denying, limiting, or delaying benefits or health care services.

How to access criteria for **Utilization Management decisions**

Our UM team bases coverage decisions only on the appropriateness of care and the service provided.

All Prestige Health Choice providers and members may receive, at no cost, a copy of our criteria for UM determinations. Our provider and member handbooks, and UM determination letters, describe how to obtain a copy of the clinical criteria we use for UM determinations.

To receive a fax copy of these criteria, providers may contact the UM team at **1-855-371-8074**.

Refer members to **Care Management**

Prestige Health Choice has Care Managers to help keep our members healthy. Our Care Management programs help with long-term illnesses, injuries, pregnancy, and mental health. We have health programs for conditions like asthma, pregnancy, heart problems, and diabetes. These programs are offered to members at no cost to them. Please visit **www.prestigehealthchoice.com** for more information.

We welcome you to refer members for support from our clinical Care Managers. Our Care Managers are registered nurses who assist members with coordinating care and linking to services that best meet their needs.

If you have a member who is struggling to connect with Prestige Health Choice services or has special health care needs, please call our Rapid Response and Outreach Team at **1-855-371-8072**.

Drug formulary information

The Prestige Health Choice formulary is the Florida Medicaid Preferred Drug List (PDL) and is subject to revision following consideration and recommendations by the Pharmaceutical and Therapeutics (P&T) Committee and the Agency for Health Care Administration (AHCA).

Formulary changes

Changes made to the formulary as a result of the latest AHCA P&T Committee meeting are available on the Prestige Health Choice website at **www.prestigehealthchoice.com/provider/find-provider** or on **ahca.myflorida.com/medicaid/**

Prescribed_Drug/pharm_thera/fmpdl.shtml. Formulary changes may be communicated by letter, by fax, online, or via provider alerts. Prestige Health Choice will communicate these changes to you as early as possible.

Drug list details

The Prestige Health Choice formulary is available on our website at **www.prestigehealthchoice.com/provider/find-provider**.

Our formulary drug list is generic-friendly. Unless otherwise specified, in the event that a generic equivalent is available for a non-PDL brand name medication, the generic equivalent must be dispensed for the medication to be covered unless there is a medical exception.

If a non-preferred agent, or an agent that has an associated edit, is inadvertently prescribed, prescribers and pharmacists are encouraged to work together to convert the prescription to a preferred formulary agent when appropriate. Our comprehensive formulary includes details about age, prior authorization, and other coverage requirements.

Medical exception process

Non-PDL formulary agents may be available through the prior authorization process. Typically, if formulary criteria have been met and the preferred formulary agents have failed or are not medically appropriate, then a non-preferred agent may be considered for coverage. Again, all supporting documentation must be submitted for us to consider covering a non-preferred agent.

Should a non-preferred agent be clinically and therapeutically most appropriate for a member, the prior authorization process will allow for a coverage determination.

Clinical edits

Clinical edits for specific medications, including prior authorization and age requirements, are included in the formulary. Prior Authorization Request Forms must be completed and submitted with supporting documentation (such as medical history and previous therapies) to process requests for these medications. These forms are available on the Prestige Health Choice website at **www.prestigehealthchoice.com/provider/resources/forms**.

PerformRx℠ provides pharmacy benefit management services to Prestige Health Choice.

- You may fax prior authorization requests to PerformRx at **1-855-825-2717**.
- For pharmacy questions, call the Pharmacy Help Desk at **1-855-371-3963**, 24 hours a day, seven days a week. Upon approval of a specialty authorization, you may forward the corresponding prescription to PerformSpecialty® via fax at **1-844-489-9565** for prompt service. You can contact PerformSpecialty by phone at **1-855-287-7888**.
- If you need further assistance, please call Prestige Health Choice Provider Services at **1-800-617-5727**.

Billing guidelines for **well-child visits**

For well-child visits, services are identified using the CPT Preventive Medicine Services codes. In some cases, one or two modifiers are required to uniquely identify the service provided.

Each preventive medicine service code billed must have a referral code, with the exception of Family Planning services (99383–99385 with modifier FP, or 99393–99395 with modifier FP), which do not require a well-child referral code.

Procedure codes

- **99381:** New Patient Under One Year
- **99382:** New Patient Ages 1–4 years
- **99383:** New Patient Ages 5–11 Years
- **99384:** New Patient Ages 12–17 Years
- **99385 EP:** New Patient Ages 18–20 Years
- **99391:** Established Patient Under One Year
- **99392:** Established Patient Ages 1–4 years
- **99393:** Established Patient Ages 5–11 Years
- **99394:** Established Patient Ages 12–17 Years
- **99395 EP:** Established Patient Ages 18–20 Years

Modifiers

- **EP:** used with procedure codes 99385 and 99395 to identify children 18 through 20 years of age.
- **FP:** used with procedure codes 99383–99385 or 99393–99395 when the appropriate diagnosis is billed for Family Planning services.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) referral codes

Providers who submit paper claims must complete field **24H** (EPSDT Family Plan) on the CMS 1500 claim form.

- **AV:** Available-not used (recipient refused referral).
- **NU:** Not used (no EPSDT recipient referral given).
- **S2:** Under treatment (recipient currently under treatment for referred diagnostic or corrective health problem).
- **ST:** New service requested (recipient referred to another provider for diagnostic or corrective treatment or scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals).

Electronic claims

Providers who bill electronically using the 837P format must select the appropriate response for ASC X12N 837: Loop 2300 element CRC02 — "Was an EPSDT referral given to the patient? (Yes or No)" and provide the appropriate condition indicator in element CRC03 of the electronic claims file. Providers should also submit a value of "Y" in Loop 2400 segment SV111.

Please refer to the table below for assistance with billing EPSDT claims.

EPSDT	EPSDT and Family Planning
If an EPSDT referral was given: • Loop 2300, Segment CRC02 = **Y** • Loop 2300, Segment CRC03 = one of the following: - **AV** Available-not used (recipient refused referral) - **S2** Under treatment - **ST** New service requested • Loop 2400, Segment SV111 = **Y** If the service is an EPSDT service and no follow-up services are required: • Loop 2300, Segment CRC02 = **N** • Loop 2300, Segment CRC03 = **NU**	If an EPSDT referral was given: • Loop 2300, Segment CRC02 = **Y** • Loop 2300, Segment CRC03 = one of the following: - **AV** Available-not used (recipient refused referral) - **S2** Under treatment - **ST** New service requested • Loop 2400, Segment SV111 = **Y** • Loop 2400, Segment SV112 = **Y** If the service is an EPSDT service and no follow-up services are required: • Loop 2300, Segment CRC02 = **N** • Loop 2300, Segment CRC03 = **NU**

Make sure you get news and updates!

At Prestige Health Choice, we are committed to delivering timely communication of health plan updates. Please be sure we have your correct fax and/or email contact information. You can update your information by using the provider portal on our website, or by contacting your Account Executive or Provider Services at **1-800-617-5727**.

Stay up to date on plan news and resources by visiting us at **www.prestigehealthchoice.com**.

Flu vaccine

The 2020–2021 flu season is here. Remind patients to get flu shots covered by Prestige Health Choice at no cost to our members. Many of the pharmacies in our network can administer the flu vaccine. Members can locate a participating pharmacy online at **www.prestigehealthchoice.com**. Also offered at no cost are adult pneumonia and shingles vaccines.

Electronic funds transfer (EFT) is available at no cost to you

Prestige Health Choice strongly recommends that our network providers enroll in EFT to streamline the payment process. We contract with Change Healthcare to give you the capability of receiving payment through EFT.

Benefits of using EFT include:

- Allows for prompt, easy, and secure payments.
- Eliminates the need to go to the bank or use mobile deposit.
- Allows you to view and print remittance advices online.
- Enables you to work with multiple payers in one easy-to-use application.

To register for EFT, complete the E-Payment Enrollment Authorization Form on the Change Healthcare Medical and Hospital EFT Enrollment Forms webpage at **https://support.changehealthcare.com/customer-resources/enrollment-services/medical-hospital-eft-enrollment-forms**.

Email the completed form to **EFTenrollment@changehealthcare.com** or fax it to **1-615-238-9615**.

After you have submitted the form and required documentation, you can expect your EFT enrollment to be processed in approximately 15 business days. After your registration is complete, you will receive a small test deposit (less than a dollar). You must confirm receipt of this deposit for your EFT account to be activated.

After your EFT account has been activated, any claims that are ready to be paid on or after the EFT setup is complete will be paid electronically.

If you have questions, please contact Change Healthcare at **1-866-506-2830**.

Electronic claims submission

Prestige Health Choice strongly encourages our providers to submit claims electronically through electronic data interchange. To initiate the electronic claims submission process or to get more information, contact Change Healthcare at **1-877-363-3666**. The Prestige Health Choice payer ID number is **77003**.

Cultural competency and language access services

At Prestige Health Choice, we recognize the diverse population of members representing various racial and ethnic groups in our communities. We understand that it is our responsibility, along with that of our extensive provider network, to effectively connect with our diverse member population. As a result, we established a Culturally and Linguistically Appropriate Services (CLAS) program.

The program uses the national CLAS standards developed by the U.S. Department of Health and Human Services' Office of Minority Health as the guide and baseline of standards.

Here are a few CLAS provider tools to remember:

- Speak directly to the patient, not the interpreter.
- Don't rush. Pause every sentence or two for interpretation.
- Use plain language. Avoid slang and sayings. Jokes don't always translate well.
- Check understanding occasionally by asking the patient to repeat back what you said. This is better than asking, "Do you understand?"

For more information, please visit **www.prestigehealthchoice.com**.

Behavioral health network

We would like to inform you of an important change in our behavioral health network of providers. Beginning **January 1, 2021**, the management of behavioral health and substance use benefits will transition from Optum Behavioral Health to Prestige Health Choice. Bringing the management of the

behavioral health services in-house will allow us to more fully integrate medical care with behavioral health care, creating a more holistic approach. If you have questions about this upcoming change, please contact your Account Executive or Provider Services at **1-800-617-5727**.

Language access services

We offer language services to facilitate better communication between members and their providers. Interpretation services are available at no cost to any Prestige Health Choice member who requires them.

These services provide a fast and easy way to communicate with our members with limited English proficiency (LEP) via interpreters in more than 200 languages. Language access is available 24 hours a day, seven days a week. To access this service for your Prestige Health Choice patients, call our Member Services department at **1-855-355-9800** (**TTY 1-855-358-5856**).

Telemedicine services

Prestige Health Choice encourages providers to use telemedicine to ensure members are receiving needed services. Please offer telemedicine appointments whenever possible to close care gaps. Also, we can assist members with technology barriers. Prestige Health Choice offers access to a smartphone at no cost (one per household for members 18 and over). The member can call **1-877-631-2550** and use promo code AMERIHEALTH to get set up. Providers must use interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time, interactive communication between a member and a practitioner. Please remember to include modifier GT on the CMS 1500 claim form to indicate the service was delivered via telemedicine.

Updating provider demographics

If you need to make changes to the following information, please contact Provider Services at **1-800-617-5727**:

- Office phone number or fax number.
- Office addresses.
- Remittance addresses.
- Hours of operation.
- New providers at your practice.

Important phone and fax numbers

Department
24-hour Nurse Call Line: **1-855-398-5615**
Bright Start® maternity program Phone: **1-855-371-8076** Fax: **1-855-358-5852**
Claim status: **1-800-617-5727**
Fraud, waste, and abuse: **1-866-833-9718**
Healthy Behaviors program Phone: **1-855-236-9281**
Integrated Health Care Management Phone: **1-855-371-8072** Fax: **1-855-358-5851**
Member complaints: **1-855-355-9800**
Member grievances and appeals Phone: **1-855-371-8078** Fax: **1-855-358-5847**
Member Services department Phone: **1-855-355-9800** TTY: **1-855-358-5856**
Provider complaints: **1-800-617-5727** Fax: **1-855-358-5853**
Provider Services department Phone: **1-800-617-5727** Fax: **1-855-358-5849**
Quality Improvement program Fax: **1-855-358-5854**
Rapid Response and Outreach Team Phone: **1-855-371-8072** Fax: **1-855-236-9281**
Utilization Management Phone: **1-855-371-8074** Inpatient fax: **1-855-236-9293** Prior authorization fax: **1-855-236-9285**

Why is **HEDIS® important?**

Prestige Health Choice is committed to offering quality preventive care and service to our members. The Healthcare Effectiveness Data and Information Set (HEDIS) helps us to monitor how we are performing compared to other health plans and identify areas of opportunity for improvement.

As a network provider, HEDIS can help you:

- Monitor patients' health, prevent further complications, and identify future health care issues that could arise.
- Identify patients who have not received preventive screenings.
- Understand how you compare with other providers based on NCQA national benchmark.

What can you do to improve HEDIS scores?

- Make sure that the services you provide are performed in a timely manner.
- Submit valid codes for HEDIS on an encounter or claim.
- Document your services and results in the patient's medical chart.
- Encourage your patients to schedule preventive exams.
- Remind your patients to follow up with ordered tests.
- Complete outreach calls to patients who have missed services.

We would like to highlight the following measures:

Cervical Cancer Screening: This measure assesses either women ages 21 to 64 who had a cervical cytology (Pap test) performed every three years or women ages 30 to 64 who had cervical cytology and HPV co-testing every five years.

Comprehensive Diabetes Care: This measure is directed to patients ages 18 to 75 who have Type 1 or Type 2 diabetes, and lists the following tests and exams:

- HbA1c testing. Completed at least annually:
  - HbA1c result >9 = poor control.
  - HbA1c result <8 = in control.
- Dilated retinal eye exam. Performed in previous two years.
- Medical care for nephropathy. At least one of the following: nephropathy screening, ACE/ARB therapy, or documented evidence of nephropathy.
- Blood pressure. Lower than 140/90 mm Hg is considered in control.

Please make sure your patients are receiving these services.

Prestige Health Choice has been monitoring closely the Centers for Disease Control and Prevention (CDC) and AHCA for the latest information about COVID-19. Please refer to these resources and the provider alert section at **www.prestigehealthchoice.com** for any updates.

Searchable online provider directory

Your practice demographic information is important. Please visit **www.prestigehealthchoice.com/provider/find-provider/index.aspx** to review and confirm that your information in our provider directory is accurate. If you notice any errors in the directory, please notify your Account Executive or Provider Services at **1-800-617-5727**.

If your Prestige Health Choice patients need information about our services and benefits in a language other than English, please have them call Member Services at **1-855-355-9800** (**TTY 1-855-358-5856**). We are committed to serving all of our members and we have interpreters for many languages your patients may need. We can also provide your patients with written materials in other languages.

Fraud Tip Hotline: **1-866-833-9718**, 24 hours a day, seven days a week.

Secure and confidential. You may remain anonymous.

Prestige HEALTH CHOICE®
Leading the Way to Quality Care

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