Prestige Health Choice Behavioral Health Provider Training

Behavioral Health Integration, Effective January 1, 2021

Revised November, 2020

Prestige HEALTH CHOICE®
Leading the Way to Quality Care

Delivering the Next **Generation** of Health Care

Overview

- Who We Are
- Management of Behavioral Health Services
- Transition of Care
- Prestige Health Choice Standard and Expanded Benefits
- Prior Authorization Benefits
- Claim Submission Guidelines
- EFT Enrollment
- Telehealth Solutions
- Reporting and Preventing Fraud, Waste, and Abuse
- Resources
- Contact Information

Who We Are

Prestige Health Choice is part of the AmeriHealth Caritas Family of Companies. AmeriHealth Caritas is one of the nation's leaders in health care solutions for those most in need. With our mission-driven legacy, we're more than just another health insurance company. Every day, we put care at the heart of our work for our members, their families, and our providers.

Our Vision
Leading America in health care solutions for the underserved.

Our Mission
We help people get care, stay well and build healthy communities. We have a special concern for those who are underserved.

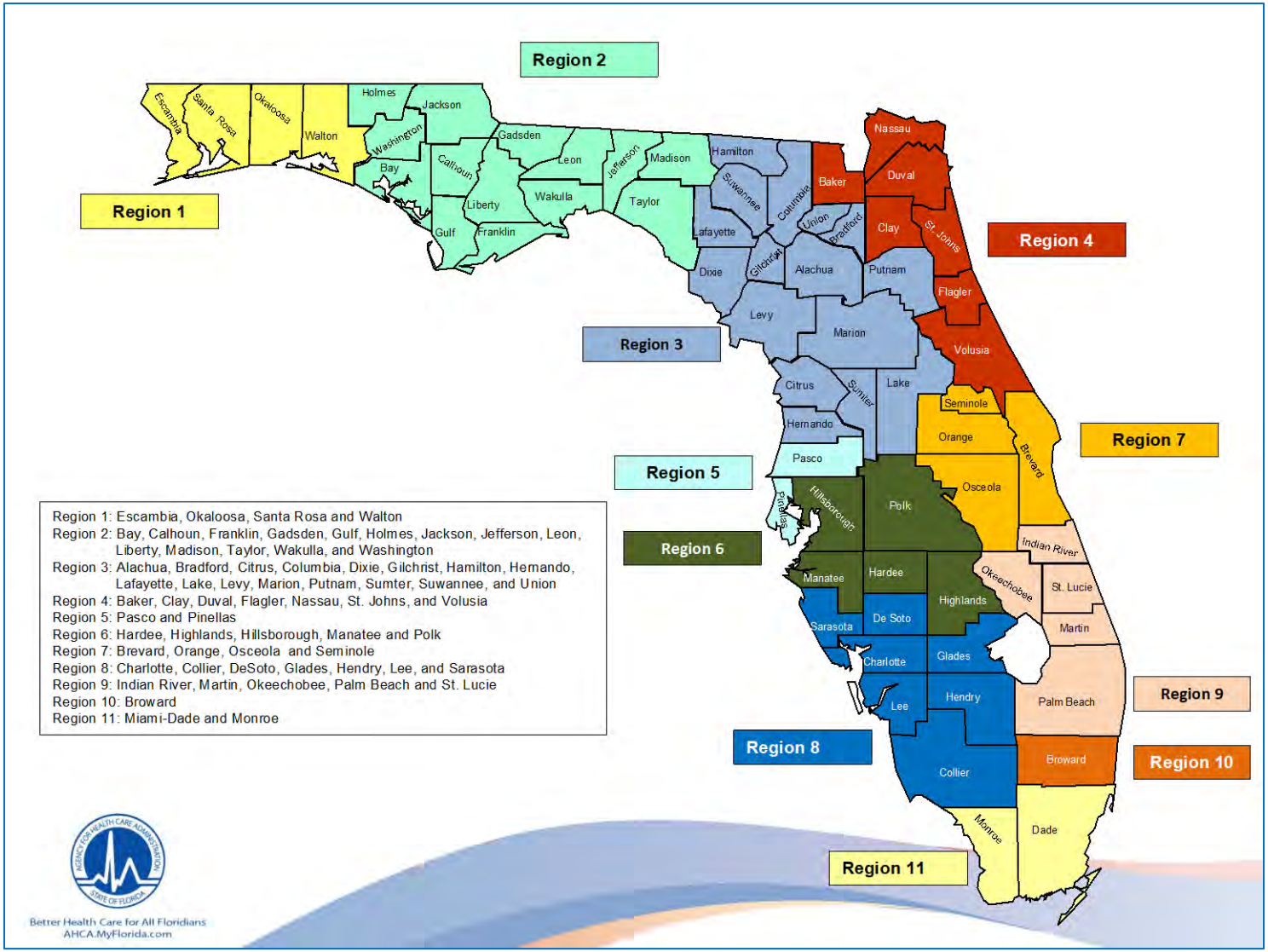
Our Values

- Advocacy.
- Care of the underserved.
- Compassion.
- Competence.
- Dignity.
- Diversity.
- Hospitality.
- Stewardship.

Where We Are

Prestige Health Choice operates in Regions 9 and 11.

- **Region 9:** Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties.
- **Region 11:** Miami-Dade and Monroe counties.



Management of Behavioral Health Services

Effective January 1, 2021, the management of behavioral health and substance use benefits will transition from Optum Behavioral Health to Prestige Health Choice.

We will cover medically necessary inpatient, outpatient, and rehabilitative behavioral health services that are included in Medicaid coverage and provided by medical professionals, licensed independent providers, and state agencies.

Transition of Care

Prestige Health Choice's goal is to make any necessary transition of care a smooth one for participants currently in treatment.

If a Prestige Health Choice member is receiving covered services from an Optum network provider prior to January 1, 2021, who is not currently participating in the Prestige Health Choice Network, there is a transition benefit available.

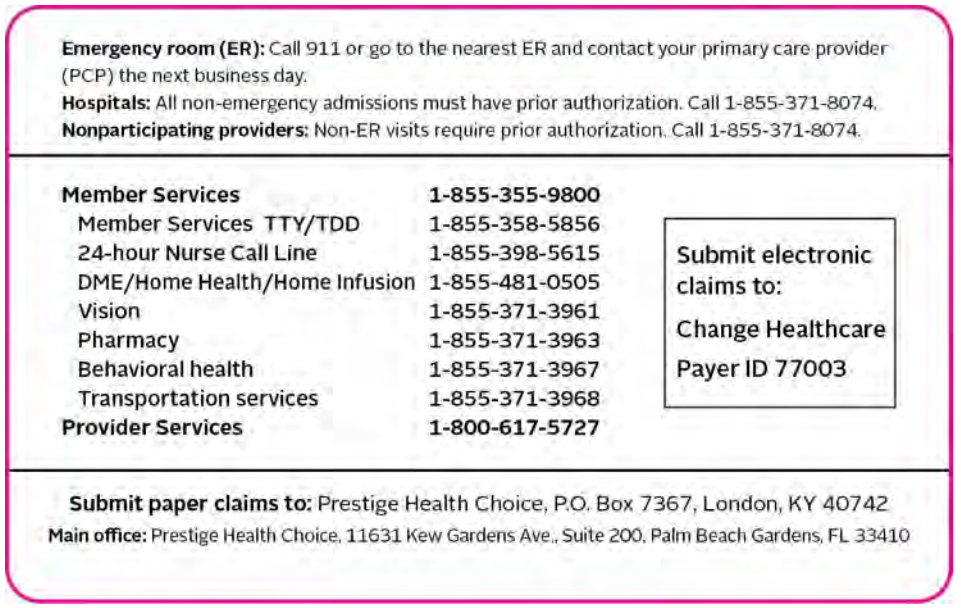
If you are not in the Prestige Health Choice network, your patients are entitled to a continuity of care (COC) period where members are allowed to continue receiving medically necessary services for a minimum of ninety (90) days after the Optum contract termination, but for a period no greater than six months.

After the member's continuity of care period, Prestige Health Choice members must receive services from a Prestige Health Choice in-network provider.

How to become a Prestige Health Choice provider:
Complete the Request to Contract form to get started. Follow the link below and select **"Become a participating provider."**

https://www.prestigehealthchoice.com/provider/behavioral-health.aspx

How to Identify Prestige Health Choice Members



Prestige Health Choice Standard Benefits

Service	Description	Coverage/Limitations	Prior Authorization
Addictions Receiving Facility Services	These services are used to help people who are struggling with drug or alcohol addiction and need hospitalization.	Covered	Yes
Ambulatory Detoxification Services	Services provided to people who are withdrawing from drugs or alcohol without going into the hospital.	Covered	Yes
Behavioral Health Assessment Services	Services used to identify mental health or substance abuse issues.	Covered	No
Behavioral Health Overlay Services	Behavioral health services provided to children (ages 0 – 18) enrolled in a Department of Children and Families (DCF) program.	Covered	No
Crisis Stabilization Unit Services	Emergency mental health services performed in a facility that is not a regular hospital.	Covered	Yes
Family Therapy Services	Services for families to have therapy sessions with a mental health professional.	Covered	No
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional.	Covered	Yes
Inpatient Hospital Services	Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors, and equipment that is used to treat you.	Covered based on age and situation: • Up to 365/366 days for recipients ages 0 – 20. • Up to 45 days for all other recipients (extra days are covered for emergencies).	Yes
Medication-Assisted Treatment services	Services used to help people who are struggling with drug addiction.	Covered	No
Medication Management services	Services to help people understand and make the best choices for taking medication.	Covered	Yes

Prestige Health Choice Standard Benefits (continued)

Service	Description	Coverage/Limitations	Prior Authorization
Mental Health Partial Hospitalization Program Services	Treatment provided for four or more hours per day, several days per week, for people who are recovering from mental illness.	Covered	Yes
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses.	Covered[1]	No
Mobile Crisis Assessment and Intervention Services	A team of health care professionals who provide emergency mental health services, usually in people's homes.	Covered	No
Outpatient Hospital Services	Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies, and treatments, visits from doctors, and equipment that is used to treat you.	Covered	Yes
Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other health care provider.	Covered[1] • Up to a 34-day supply of drugs, per prescription. • Refills, as prescribed.	Refer to online Preferred Drug Listing www.prestigehealthchoice.com.
Psychiatric Specialty Hospital Services	Emergency mental health services that are performed in a facility that is not a regular hospital.	Covered[1]	Yes
Psychological Testing Services	Tests used to identify behavioral health problems.	Covered[1]	Yes
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money, and performing household chores.	Covered[1]	Yes

Prestige Health Choice Standard Benefits (continued)

Service	Description	Coverage/Limitations	Prior Authorization
Self-Help/Peer Services	Services to help people who are in recovery from an addiction or mental illness.	Covered[1]	Yes
Specialized Therapeutic Services	Services provided to children ages 0 – 20 with mental illnesses or substance use disorders.	• Covered[1] • Assessments • Foster care services • Group home services	No
Statewide Inpatient Psychiatric Program Services	Services for children ages 0 – 20 with severe mental illnesses who need treatment in a facility.	Covered for children ages 0 – 20	Yes
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 0 – 20 with behavioral health issues from being placed in a hospital or other facility.	Covered for children ages 0 – 20	No

Prestige Health Choice Expanded Benefits

Expanded benefits are the AHCA-approved services that are additional benefits specified in the AHCA contract. These expanded benefits may be subject to medical necessity and prior authorization. **The following expanded benefits are available to Prestige Health Choice members:**

Service	Description	Coverage/Limitations	Prior Authorization
Assessment Services	In-depth assessment for substance use issues.	Covered, no limit	No
	Psychological testing to identify behavioral health problems.	Covered, no limit	Yes
Behavioral Health Day Services/Day Treatment	Daytime treatment for behavioral health needs related to everyday living.	Covered, no limit Must be active in case management	No
	Adult day care services.	Covered, no limit	Yes
Behavioral Health Screening Services	Assessments and screening services for mental health and substance use issues.	Covered, no limit	
Behavioral Health Medical Services (Verbal Interaction)	Talking with a medical professional about your mental health and/or substance use needs.	Covered, no limit	Yes
Behavioral Health Medical Services (Medication Management)	Services with a medical professional who can treat mental health and substance use issues with medication.	Covered, no limit	Yes
Behavioral Health Medical Services (Drug Screening)	Alcohol and other drug screening with urine samples.	Covered, no limit	Yes
Cellular Phone Service	This benefit can help members stay in touch with Prestige or their providers.	Covered One smartphone; monthly call minutes and data; unlimited text messages; unlimited calls to Prestige Health Choice Member Services. (One per household for members 18 and older. Certain limitations may apply based on FCC guidelines.)	

Prestige Health Choice Expanded Benefits (continued)

Service	Description	Coverage/Limitations	Prior Authorization
Computerized Cognitive Behavioral Analysis	Health and behavior services, including assessments and therapy with a group, the member's family, or one-to-one sessions with a mental health professional while the member has a physical illness.	Covered, no limit	No
	Family health and behavior intervention; family (without the patient present).	Covered, no limit	No
Home Visit by a Clinical Social Worker	Services to provide support and education that will help to improve the quality of life for high-risk pregnant moms.	Covered Limited to 24 visits per year for high-risk pregnant members; requires physician order.	Yes
Intensive Outpatient Treatment	Outpatient treatment services in a program for substance use that meets three days per week for three hours each day.	Covered, no limit	Yes
Massage Therapy	Therapy that is used for the treatment of pain. Commonly, massage is applied with a therapist's hands and fingers.	Covered Annual maximum of 12 visits for medical massage provided by a participating physical therapy or chiropractic provider.	Prior authorization required for physical therapist. No prior authorization needed for chiropractor.
Medication-Assisted Treatment	A licensed program that gives medication to lessen withdrawal symptoms from drugs or alcohol, along with supportive counseling.	Covered, no limit	No
Over-The-Counter Medication	Provides health supplies and items such as aspirin, vitamins, first aid items, and cough medicine.	Covered $25 per household per month; purchases limited to approved products.	No

Prestige Health Choice Expanded Benefits (continued)

Service	Description	Coverage/Limitations	Prior Authorization
Therapy (art)	Art uses creative activities, such as drawing and painting as part of treatment.	Covered Up to seven outpatient sessions per year, 21 years and older.	Yes
Therapy (equine)	Uses horseback riding with a behavioral health professional as part of treatment.	Covered Up to three outpatient sessions per year for enrollees with a substance use disorder or chronic condition under care management, ages 21 and older.	Yes
Therapy (group)	Therapy for a group of people with a mental health professional.	Covered, no limit	No
Therapy (individual/family)	Training and educational services about how to care for the member's disabling mental health problems.	Covered, no limit	No
Therapy (pet)	Volunteers and their pets to help with treatment or therapy.	Covered Up to three sessions per year for members under care management for a chronic condition; inpatient care only while member is in an acute care hospital for treatment; ages 21 and older.	Yes
Therapeutic Behavioral On-Site Services	Services provided by a team to support behavioral health issues and keep you from being placed in a hospital or other facility.	Covered, no limit	No
Targeted Case Management	Help with getting health care and behavioral health services.	Covered, no limit	No

Please visit **www.prestigehealthchoice.com** for a full list of expanded benefits.

Prior Authorization Requirements

Authorization for outpatient services. Prior authorization is required before the service is provided.

For psychological and neuropsychological testing, providers can request prior authorization in two different ways:

- Submit the prior authorization request in Availity.
- Complete the **Psychological/Neuropsychological Testing Request form** found on our website at: **www.prestigehealthchoice.com/provider/resources/forms.aspx**, then fax the form to **1-855-236-9285.**

Authorization for higher levels of care, including Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP), Inpatient Program (IP), Detoxification, Statewide Inpatient Psychiatric Program Services (SIPP), and Rehabilitation.

Providers can request prior authorization in two different ways:

- Complete the **Behavioral Health Fax form** found on our website at: **www.prestigehealthchoice.com/provider/resources/forms.aspx**, then fax the form to **1-855-236-9293.**
- Contact Utilization Management (UM) at **1-855-371-8074**. For urgent precertification requests for acute care, UM is available 24 hours a day, seven days a week.

Prestige Health Choice follows all timeliness requirements for prior authorization requests, which include responding in seven days for a standard request and in two days for an expedited request.

Claims Submission Guidelines

All claims **must** be billed on a CMS 1500 for submission to Prestige Health Choice for payment.

For line-by-line instruction on how to complete a claim form (CMS 1500), go to AHCA's website at this link: **http://ahca.myflorida.com/medicaid/review/Reimbursement/RH_08_080701_CMS-1500_ver1_4.pdf**.

Providers may also submit claims through **www.changehealthcare.com.**

Clearinghouse Information: Provider can use vendor of choice.

You can submit your claims two ways:

- **Electronic Claim Submission:**
  Prestige Health Choice Payer ID #77003

- **Paper Claims Submission:**
  Prestige Health Choice
  P.O. Box 7367
  London, KY 40742

Time frame for Claim Submission: 180 days from the date of service (unless your contract specifies otherwise).

Claims Customer Service: 1-800-617-5727

Claims Submission Guidelines (continued)

Provider hints to avoid denials:

Make sure every National Provider Identifier (NPI) on the claim form matches an active Fully or Limited Enrolled Medicaid ID on the AHCA State Table.

To review the AHCA State Table:

- **http://portal.flmmis.com/flpublic/Provider_ManagedCare/Provider_ManagedCare_Registration/tabid/77/desktopdefault/+/Default.aspx.**
- Click on: **Provider Master List spreadsheet.** Download and open the spreadsheet.
- Search the spreadsheet by **NPI** or **Medicaid ID.**
- Make certain that the NPI Crosswalk Effective dates and Medicaid Claims Eligibility dates are active.
- If State Table needs to be updated/corrected, please contact AHCA directly at: **1-800-289-7799.**

Electronic Fund Transfer (EFT) Enrollment

Payment options. As of October 23, 2020, Prestige Health Choice is now offering more choice in payment methods. Electronic claim payment has the added benefit of reducing potential exposure risk associated with paper checks.

Virtual credit card (VCC) services. VCC payment is your default payment method, instead of paper checks. Your office will receive either faxed or mailed VCC payments, each containing a VCC with a number unique to that payment transaction, your Explanation of Payment (EOP), and an instruction page for processing. Normal transaction fees apply based on your merchant acquirer relationship. To opt out of this VCC payment method, you can contact ECHO® directly at **1-888-492-5579**.

Electronic fund transfer (EFT) payments.

- Payments appear on your bank statement from PNC and ECHO as "PNC –ECHO". If you are using a practice management system, be sure your software reflects the new ECHO payer ID 58379 in addition to the Prestige Health Choice payer ID 77003 to receive Electronic Remittance Advices (ERAs).

- All generated ERAs will also be accessible to download from the ECHO provider portal (**www.providerpayments.com**). Changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO Health Enrollment team at **1-888-834-3511**.

Electronic Fund Transfer (EFT) Enrollment
(continued)

New to EFT payments. If you are interested in receiving payment via EFT, setting up EFT is fast and straightforward. In addition to your banking account information, you will need to provide an ECHO payment draft number and payment amount as part of the enrollment authentication. Please note: Payments from Prestige Health Choice will appear on your bank statement from PNC and ECHO as "PNC–ECHO".

- To sign up to receive EFT from Prestige Health Choice and any affiliated plans in the AmeriHealth Caritas Family of Companies, visit **https://enrollments.echohealthinc.com/efteradirect/enroll**. You only need to enroll once for all Prestige Health Choice affiliated plans and **there is no fee**.

- To sign up for EFT, from **all** payers you work with to process payments on the ECHO platform, visit **https://enrollments.echohealthinc.com/. A fee for this service may apply.**

MedPay. If you are not enrolled with us to receive payments via EFT, you opt out of VCC, and have enrolled for Medical Payment Exchange (MPX) with another payer, you will continue to receive your payments in your MPX portal account. Otherwise, you will receive a paper check via print and mail.

Paper checks. To receive paper checks and paper EOPs, you must opt out of the VCC services by contacting ECHO Health at **1-888-492-5579** after your initial VCC payment is received.

In addition, we want to make you aware that you will also be able to log into www.providerpayments.com to access a detailed EOP for each payment from Prestige Health Choice.

How to Submit a Provider Complaint

You may dispute Prestige Health Choice's claims, billing disputes and service authorizations by following the instructions below:

- Download the Provider Complaint Form at **www.prestigehealthchoice.com**.
- Submit the completed Provider Complaint Form via mail or fax:

  Mail: Prestige Health Choice
  Attn: Provider Complaints
  P.O. Box 7366
  London, KY 40742

  Fax: **1-855-358-5853**

If the appeal is of a **claims** nature, please include all relevant information to support your appeal, including but not limited to fee schedules, copy of contract, Remittance Advice, calculations, or other information to support the request.

A provider has 90 calendar days from the clinical decision or claims payment date to submit an appeal. All appeals past that date will be administratively upheld.

Prestige will send an acknowledgement letter within three business days to inform you that we have received your appeal.

Prestige Health Choice will resolve all provider appeals within 60 calendar days.

Telehealth Solutions

Prestige Health Choice readily embraces telehealth to better engage members in their care and improve outcomes. Prestige can even assist members with technology barriers. Prestige offers a **smartphone at no cost** (one per household for members 18 and older). The member can call **1-877-631-2550** and use the promo code **AMERIHEALTH** to get registered.

If your practice meets the current telehealth requirements indicated, please obtain a copy of the Telehealth Attestation form from **www.prestigehealthchoice.com** so that we can inform members of your telehealth service option. The completed form can be returned to: **PNM_Inquiries@prestigehealthchoice.com.**

Requirements

- Telehealth must be provided by practitioners licensed within their scope of practice to perform the service.
- Telehealth services must use interactive telecommunications equipment that minimally includes real-time, two-way interactive communication between a recipient and a practitioner using audio and video equipment.
- Telecommunications equipment and telehealth operations must comply with technical safeguards in 45 CFR 164.312, where applicable.
- Providers must comply with HIPAA regulations related to telehealth communications.
- Providers must include the modifier GT on the CMS-1500 claim form to indicate a telehealth service.

Prestige Health Choice follows the relaxed guidelines enacted due to COVID-19 as endorsed by AHCA. Please continue to follow AHCA's requirements on telehealth.

Telehealth Solutions (Continued)

Documentation

When treating Prestige Health Choice members, please include the following items in your documentation for telehealth services:

1. Documentation regarding the use of telehealth must be included in the medical record or progress notes for each encounter.
2. Documentation of equipment used for the covered, eligible telehealth services provided.
3. A signed statement from the patient or his/her authorized representative indicating their choice to receive telehealth services. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided.

To obtain a copy of the Telehealth Attestation form or find more information on telehealth, please visit www.prestigehealthchoice.com.

Reporting and Preventing Fraud, Waste, and Abuse

Prestige is obligated to ensure the effective use and management of public resources in the delivery of services to its members. Prestige does this in part through its Program Integrity department whose programs are aimed at the accuracy of claims payments and to the detection and prevention of fraud, waste, or abuse.

In connection with these programs, you may receive written or electronic communications regarding payments or recovery of potential overpayments. The Program Integrity department utilizes both internal and external resources, including third-party vendors, to help ensure claims are paid accurately and in accordance with your provider contract.

Reporting and Preventing Fraud, Waste, and Abuse

Compliance with state and federal laws and regulations is mandated. Providers and members may anonymously report suspected fraud, waste, or abuse to the Special Investigations Unit (SIU). Please provide as much information as possible or available using one of the following methods:
Via telephone by calling the Fraud Tip Line at **1-866-833-9718.**

- By sending an email to **FraudTip@amerihealthcaritas.com.**
- Via postal service.
- Online using the Fraud Tip form at **http://home.kmhp.com/index.asp?go=/fraud/.**
- Directly to the state oversight agency.

Resources

Provider Manual
www.prestigehealthchoice.com/pdf/provider/provider-manual-new.pdf

Prestige Health Choice Behavioral Health information and forms
www.prestigehealthchoice.com/provider/behavioral-health.aspx

Behavioral Health Quick Reference Guide
www.prestigehealthchoice.com/pdf/provider/forms/behavioral-health-provider-quick-reference-guide.pdf

Provider Training
www.prestigehealthchoice.com/provider/training-and-education/index.aspx

Cultural Competency
https://dev.prestigehealthchoice.com/provider/resources/cultural-competency.aspx

Availity Provider Portal
We recommend registering for Availity's secure provider portal at www.availity.com/providers/registration-details/ to access member eligibility and benefits, claim status, authorization submission and inquiry, and reporting. If you need assistance, call **1-800-AVAILITY**.

Contact Information

Department	Phone Number	Fax number
24-hour Nurse Call Line	1-855-398-5615	
Claim Status	1-800-617-5727	
Integrated Health Care Management	1-855-371-8072	1-855-358-5851
Member Complaints	1-855-355-9800	
Member Grievances and Appeals	1-855-371-8078	1-855-358-5847
Member Services	1-855-355-9800 (TTY: 1-855-358-5856)	
Member Services, Behavioral Health	1-855-371-3967	
Provider Complaints	1-800-617-5727	1-855-358-5853
Provider Services	1-800-617-5727	1-855-358-5849
Rapid Response and Outreach	1-855-371-8072	1-855-236-9281
Utilization Management	1-855-371-8074	Inpatient: 1-855-236-9293 Prior Authorization: 1-855-236-9285

Welcome to Prestige Health Choice

Prestige
HEALTH CHOICE®
Leading the Way to Quality Care

Questions and Answers

Prestige HEALTH CHOICE®

Leading the Way to Quality Care

Care is the **heart** of our **work.**

Prestige HEALTH CHOICE®

Leading the Way to Quality Care

ACFL-211107815-1