Do you have patients who could benefit from Integrated Health Care Management?

Primary care settings are often a gateway to health system access. As such, primary care providers (PCPs) may rely on support and resources to treat individuals with a variety of health care needs. One such support mechanism we encourage providers to take advantage of is our Integrated Health Care Management (IHCM) program.

The IHCM program offers a coordinated approach to the member’s care by integrating physical health, behavioral health, and social and environmental factors into an overall plan of care with the goal of improving health outcomes. The program is designed to address the health needs of many of our members. The goals of the program are:

- To fully engage and actively case manage targeted members in the IHCM program.
- To integrate clinical guidelines into the management of high-risk members with asthma, diabetes, heart disease including hypertension, and chronic obstructive pulmonary disease (COPD).
- To facilitate member education and awareness through multidisciplinary initiatives.
- To improve member access to PCPs, specialists, and other medically necessary services through collaboration with providers.
- To improve compliance with clinical guidelines.
- To ensure timely access to the appropriate level of care based on member acuity status.

You may have patients who could benefit from Integrated Health Care Management. If you have a Prestige Health Choice patient who could benefit from an ongoing or episodic care management screening, please consider referring him or her to our IHCM program.

(continued inside)
The peer-to-peer review process

Prestige Health Choice network providers have the right to a peer-to-peer review of authorization requests that are determined not to meet medical necessity.

If an authorization request is determined not to meet medical necessity, the provider will be notified verbally or via fax, with a letter of denial to follow, confirming this initial determination. The denial letter informs the member of his or her right to an appeal and clearly documents the reason for the denial.

The requesting provider has the right to a peer-to-peer review with a Prestige Health Choice Medical Director within three business days of the verbal or fax notification.

A Medical Director will respond to requests for a peer-to-peer discussion from the requesting provider within one business day. If the Medical Director who originally reviewed the authorization request is not available within that time frame, the request for peer-to-peer review will be forwarded to another Medical Director.

If you have any questions, please call Prestige Health Choice Medical Management at 1-855-371-8074.

Thank you for your support and the valuable services you provide to our members.

IMPORTANT LEGISLATIVE UPDATE: New rule for pharmacies and providers who dispense controlled substances

As of January 1, 2018, pharmacies and providers who dispense controlled substances will have one day to report certain information to the statewide prescription drug monitoring program (PDMP).

The Florida PDMP, known as E-FORCSE* (Electronic-Florida Online Reporting of Controlled Substance Evaluation Program), was created by the 2009 Florida legislature in an initiative to encourage safer prescribing of controlled substances and to reduce drug use and diversion within the State of Florida.

E-FORCSE has selected Health Information Designs LLC to develop a database that collects and stores prescribing and dispensing data for controlled substances in Schedules II, III, and IV. The information collected by the database includes the name of the prescriber; the date the prescription is filled and dispensed; and the name, address, and date of birth of the person to whom the controlled substance is dispensed. The purpose of the PDMP is to provide the information that is collected in the database to health care providers to help inform their decisions in prescribing and dispensing these often misused prescription drugs.

Prior to January 1, 2018, Florida statute section 893.055(4) required health care providers to report to the PDMP through E-FORCSE each time a controlled substance was dispensed to an individual as soon as possible but not more than seven days after dispensing, with certain exceptions.

Beginning January 1, 2018, the amount of time a dispenser has to report the dispensing of a controlled substance to the PDMP database is reduced from seven days to the close of the next business day after the controlled substance is dispensed. The statutory change requires PDMP reporting to be completed via the Department of Health (DOH)-approved electronic system, E-FORCSE, and eliminates DOH authority to approve other options for submission.

Connections A Provider’s Link to the Prestige Health Choice Health Plan

Look for your Prestige Health Choice satisfaction survey in the mail. You can also complete this survey online. Help us identify opportunities to better serve you and your patients in 2018.
New Medicare card project (NMCP) gets underway

To meet requirements detailed in the Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act of 2015, the Centers for Medicare & Medicaid Services (CMS) will facilitate the removal of Social Security numbers from all Medicare ID cards beginning this April.

To ensure all providers and insurers have access to the most up-to-date information on this initiative, the Agency for Health Care Administration (AHCA) has created an NMCP informational page on their public web portal, at www.portal.flmmis.com/FLPublic/Provider_AgencyInitiatives/Provider_NMCP/tabid/147/Default.aspx. It includes a quick-reference guide to the project and a transition schedule, and it will be updated regularly.

CMS has also created a website that provides information about the new Medicare cards, at www.cms.gov/Medicare/New-Medicare-Card/index.html.

Do you have patients who could benefit from Integrated Health Care Management? (continued)

If your Prestige Health Choice patients need information about our services and benefits in a language other than English, please have them call our Member Services Department at 1-855-355-9800 (TTY 711). We are committed to serving all of our members and have interpreters for many languages your patients may need. We can also provide your patients with written materials in other languages.

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Connections  A Provider’s Link to the Prestige Health Choice Health Plan

Prestige Health Choice would like to inform health care providers of our affirmation statement regarding incentives:

• Utilization management (UM) decisions are based only on appropriateness of care and service and existence of coverage.

• Providers, associates, or other individuals conducting utilization management review are not rewarded by Prestige Health Choice for issuing denials of coverage or service.

• Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

FLORIDA MEDICAID
HEALTH CARE ALERT:
Provider enrollment screening enhancements

The Affordable Care Act requires that AHCA conduct pre- and post-enrollment screenings to ensure providers initially meet and continue to meet the enrollment criteria for their provider type.

As an enhancement to the provider screening process, AHCA will soon implement automated checks to compare Florida Medicaid provider application data against Medicare’s Provider Enrollment Chain of Ownership System (PECOS) database for those providers who are enrolled in both Medicare and Medicaid.

All providers currently enrolled in both Medicare and Medicaid are encouraged to review the information on their Medicare PECOS provider file, and to promptly complete any necessary updates. Items that will be checked include the provider name, tax ID number, National Provider Identifier (NPI) number, ownership, date of birth, and service address.

FLORIDA MEDICAID
HEALTH CARE ALERT:
Provider enrollment screening enhancements

Apply online to get your Florida Medicaid ID (MAID) number

Your MAID number can be obtained through the AHCA website at ahca.myflorida.com/Medicaid/index.shtml. Following the enrollment process, approved providers are issued a nine-digit Medicaid provider number and become eligible to participate in the Florida Medicaid program.

• Any person or entity that wants to be paid for rendering medical, medical-related, and waiver-related services to Medicaid recipients must complete this form to obtain their MAID prior to providing services.

• Please type or print in blue or black ink. Do not use red ink.

• You will need to provide your tax ID number, Social Security number, or federal employer identification number (FEIN).

• You will also need to include your license information, NPI number, and Medicare number.

Our Provider Enrollment department can assist you during the application process. We can also assist you if you have a change of address or change of ownership, or you want to re-enroll as a Medicaid provider. If you need assistance in obtaining your MAID number, please call us at 1-800-617-5727 or call the Florida Medicaid Program at 1-800-289-7799, option 4.
How well do you communicate with members?

Prestige Health Choice is committed to fostering ongoing improvement in member satisfaction and health outcomes. One way we do so is by developing annual action plans to improve Consumer Assessment of Healthcare Providers and Systems (CAHPS®) scores.

This year, one area for improvement focuses on how well providers communicate with our members during office visits. In the coming months, we will make available a host of educational resources to help you better communicate with members. Here are some simple tips to get you started:

- **Simplify what you say.** Think about what you want to say, then in your mind translate it into what you believe a sixth grader would understand. Make it as simple as possible. Don’t use anatomical terms. For example, say “swallowing tube” instead of “esophagus.”

- **Make sure your patients understand what you’re telling them.** Ask your patient to repeat back to you what you just said. This is called “teaching back.” It will allow you to gauge what they do understand. By listening to what they have and have not processed, you’ll get the opportunity to revisit aspects that were unclear for them.

- **Listen carefully to your patients.** After your patient finishes speaking, say, “So what you’re telling me is...” and repeat what they have told you. Your patients want to share their health concerns with you and feel that you care about their well-being.

Use your CLIA ID when filing claims

CMS requires virtually all laboratories, including physician office laboratories, to meet applicable federal requirements and have a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate to operate.

Providers that perform laboratory testing must indicate their CLIA ID number when submitting claims.

For electronic and paper claims, please enter your CLIA ID in the fields indicated below:

- **For 837 professional electronic claim submission**, please enter your CLIA ID in Loop ID 2300, segment/data element REF2.

- **For the CMS 1500 paper form**, please enter your CLIA ID in field 23 (titled “Prior authorization number”).

- It is not necessary to indicate your CLIA ID on institutional claims.

Please note that it is the responsibility of providers to make sure laboratory tests are performed within the scope of their certifications and that they have a valid current CLIA ID.

For additional information regarding CLIA, applying for or renewing a certificate, or assigned test complexity levels, please visit the CMS CLIA website, at [www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html](http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html).

If you have any questions, please contact the Provider Services department at 1-800-617-5727.
How to submit an appeal

If you have a Prestige Health Choice member who has had a claim or prior authorization denied, you have the right to write an appeal letter on their behalf, with the member’s written consent. Here is some information to help you correctly submit an appeal.

Submit member appeals to:

Member Grievances and Appeals
P.O. Box 7368
London, KY 40742
Fax: 1-855-358-5847

If you receive an authorization request denial from Prestige Health Choice, you have 45 calendar days from the date of the Notice of Adverse Benefit Determination (NABD) to request reconsideration as follows:

- Fax a request for reconsideration along with additional clinical information to 1-855-236-9285. Please include the reference number from the NABD letter on your fax cover sheet.
- During the reconsideration process, you may request a peer-to-peer discussion by contacting Prestige Health Choice Utilization Management at 1-855-371-8074. Be prepared to provide a convenient time to receive a call from the Prestige Health Choice Medical Director.
- If our decision is to overturn the original denial, Prestige Health Choice Utilization Management will notify you of the approval and provide an authorization number. You should expect a response within 14 calendar days from the date we receive your reconsideration request.
- If our decision is to uphold the original denial, Prestige Health Choice Utilization Management will notify you of the upheld denial. You should expect a response within 14 calendar days from the date we receive your reconsideration request.

If you still disagree with our decision, you have the right to file an appeal on the member’s behalf. The appeal will require the member’s signature (for hospital claims we will accept the member’s signature on the hospital admission consent forms). You may file the appeal on the member’s behalf within 30 days of notification of the upheld denial decision.

Prestige Health Choice distributes its member rights and responsibilities statement to the following groups:
1. New members, upon enrollment.
2. Existing members, annually.
Project AIDS Care (PAC) prior authorization reminders

On January 1, 2018, Prestige Health Choice assumed responsibility for the PAC waiver. The purpose of this program is to maintain and promote the health and functioning of individuals diagnosed with AIDS and to prevent hospitalizations or institutionalizations. Program participants can choose to receive services in their homes or in community-based settings.

Prior authorization for these services was not required during the continuity of care period, which ran for 60 calendar days beginning January 1, 2018. We request that any providers who rendered services to PAC waiver program members during the continuity of care period notify the Prior Authorization department prior to submitting a claim to facilitate claim payment. Providers can contact the Prior Authorization department at 1-855-371-8074, option 2.

- What are the prior authorization guidelines for restorative massage providers?
  After the continuity of care period ends, prior authorization rules apply. These rules can be found in the Prestige Health Choice provider manual, available on our website at www.prestigehealthchoice.com/provider/resources/index.aspx.

- What are the prior authorization guidelines for specialized medical equipment and supplies (such as incontinence supplies, including adult diapers, adult briefs, protective underwear, or under pads)?
  After the continuity of care period ends, prior authorization rules apply. These rules can be found in the Prestige Health Choice provider manual, available on our website at www.prestigehealthchoice.com/provider/resources/index.aspx.

REMINDER: Coastal Care Services will become our new home care services subcontractor on April 1, 2018

We are transitioning the delivery of our members’ home care services to Coastal Care Services (Coastal) effective April 1, 2018. Starting in April, Coastal, an established provider network, will begin management of our durable medical equipment (DME), home health, and home infusion services. They will be responsible for the clinical authorization and claims adjudication processes for these services.

- If you would like to become a contracted provider, please email Viviana Pietri, Credentialing Manager, at providerrelations@ccsi.care or call her at 1-833-204-4535.
- If you have any questions about the transition, call Coastal toll free at 1-855-481-0505 (TTY/TDD 711) with any questions about Prestige Health Choice member claims or requesting authorizations for a health plan member after April 1, 2018.
- Clarification regarding codes and exclusions will be coming shortly

Fraud Tip Hotline: 1-866-833-9718, 24 hours a day, seven days a week. Secure and confidential. You may remain anonymous.
Do you have patients who could benefit from integrated health care management?