PROVIDER CONNECTIONS

Prestige HEALTH CHOICE®
Leading the Way to Quality Care

2018 **ISSUE 3**

The 2018 immunization season is here. Are you ready?

Are you enrolled in Florida's VFC program as a VFC provider?

What is HEDIS®?

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A Provider's Link to Prestige Health Choice

The 2018 immunization season is **here**. Are you ready?

Reminder: Prestige Health Choice has updated its vaccine reimbursement process

This past May, we modified the way we reimburse vaccines and administration codes. All vaccine codes must now be billed with a corresponding administration code. If a vaccine is billed without a corresponding administration code, or vice versa, payment will be denied.

Prestige Health Choice does not reimburse for vaccine products included in the Vaccines for Children (VFC) program, for members ages 0 – 18, or for MediKids members (please refer to table below). For these two programs, reimbursement is only available for the administration of the vaccine; however, vaccinations should still be billed on each claim with the appropriate administration code.

Member	Vaccine	Administration
Ages 0 – 18	Covered under VFC program	Reimbursed by Prestige Health Choice
MediKids	Covered by Medicaid fiscal agent	Reimbursed by Prestige Health Choice
Ages 19 – 20	Reimbursed by Prestige Health Choice	Reimbursed by Prestige Health Choice
Ages 21 and over* Flu, pneumonia, and shingles	Reimbursed by Prestige Health Choice	Not covered

*Prestige Health Choice offers the flu, pneumonia, and shingles vaccines to members over age 21 as an expanded benefit. Please visit the Prestige Health Choice website for more information. If you have questions, please contact Provider Services at **1-800-617-5727**.

Practice management **reminders**

It's almost that time of year again. Please remember that all vaccines must be billed with a corresponding administration code. Here are some other important claims and referral reminders to keep in mind:

- Do not use resubmission code 6 on corrected claims. Please use resubmission code **7**.
- Please refer your Prestige Health Choice patients to Quest Diagnostics for routine laboratory services.
- If you are billing a referring/ordering/prescribing/attending (ROPA) provider, please include the ROPA provider's 10-digit National Provider Identifier (NPI), as well as the appropriate qualifier on the claim form.

Flu season is right around the corner. **Pre-order** your vaccine now!

The Centers for Disease Control and Prevention (CDC) recommends a yearly flu vaccine for everyone 6 months and older. Flu season is right around the corner, so pre-order your flu vaccine now and to help keep your patients healthy during this year's flu season.

Are you enrolled in Florida's Vaccines for Children (VFC) program as a **VFC provider?**

Any Florida-licensed Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Physician Assistant, or health care organization serving VFC program-eligible children can become a VFC provider. A child is eligible for the VFC program if he or she is younger than 19 years of age and is one of the following:

- Medicaid-eligible.
- Uninsured.
- Underinsured.
- American Indian or Alaska Native.

Children whose health insurance covers the cost of vaccinations are not eligible for VFC vaccines, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible had not been met.

You can enroll in the program on the Florida SHOTS website or by emailing your enrollment request to **FloridaVFC@FLHealth.gov.** A VFC representative will contact you with instructions for initial enrollment. Florida SHOTS (State Health Online Tracking System) allows you to track all shots for all patients. Enjoy fast and easy access to web-based immunization records that simplify everything from finding a patient's vaccination history and interpreting complex immunization schedules to printing an automated D.H. Form 680 for school attendance.

All vaccines are recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the CDC and the U.S. Department of Health and Human Services, and covered under the VFC program at no cost to the participating health care provider. You do not have to be a Medicaid provider to participate in the VFC program. Any health care provider authorized to prescribe vaccines under Florida law can be a VFC provider.

There is no charge for any vaccines given by a VFC provider to eligible children. But there can be some other costs with a vaccination:

- Doctors can charge a set (or standard) fee to administer each shot. But if the family cannot afford the fee per shot, the fee must be excused. A VFC-eligible child cannot be refused a vaccination because of the parent's or guardian's inability to pay for shot administration.
- There can be a fee for the office visit.
- There can be fees for non-vaccine services, like eye exams or blood tests.

Provider participation guidelines are simple. Providers continue to vaccinate VFC program-eligible children, following normal practice guidelines. Providers do not have to accept a child into their practice based solely on the child's VFC program eligibility.

Vaccines offered through the VFC program include:

- Diphtheria, tetanus, and acellular pertussis (DTaP).
- *Haemophilus influenzae* type b (HIB).
- Hepatitis A.
- Hepatitis B.
- Human papillomavirus (HPV).
- Influenza.
- Meningococcal conjugate (MCV4).
- Measles, mumps, and rubella (MMR).
- Measles, mumps, rubella, and varicella (MMRV).
- Pneumococcal conjugate (PCV13).
- Polio (IPV).
- Rotavirus.
- Tetanus and diphtheria (Td).
- Tetanus, diphtheria, and acellular pertussis (Tdap).
- Varicella.
- Combination vaccines (Pediarix®, Comvax®, Quadracel®, Pentacel®, Kinrix®, and ProQuad®).

The following vaccine is available by request for high-risk children only:

- Pneumococcal polysaccharide (PPSV23).

As the U.S. Food and Drug Administration (FDA) approves new vaccines or additional vaccine combinations and as ACIP recommends them, the VFC program includes them in its program. Contact a VFC program representative at **1-877-888-7468** for more information.

Source: **www.cdc.gov/vaccines/programs/vfc/providers/index.html**.

What is **HEDIS®?**

The Healthcare Effectiveness Data and Information Set (HEDIS) is a performance measurement tool used by more than 90 percent of America's health plans.[1]

Health plans are measured on how well they perform in quality, effectiveness of care, access to care, and member satisfaction. HEDIS measures are collected and calculated using specific CPT and ICD-10 codes found in claims and encounters data.

Through the use of different data sources, such as HEDIS, Prestige Health Choice measures the effectiveness of our initiatives and identifies opportunities for optimally supporting our network providers and members.

Why is HEDIS important?

Prestige Health Choice is committed to offering quality preventive care and service to our members. HEDIS allows 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 patient's 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 and the national average.

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.

If you have questions about HEDIS, please contact the Prestige Health Choice Quality department at **phcqidepartment@prestigehealthchoice.com.**

Become familiar with HEDIS to understand what is required of health plans and providers.

[1]**www.ncqa.org/hedis-quality-measurement**

Are you **treating** a Prestige Health Choice patient who could **benefit** from complex case management?

Prestige Health Choice offers complex case management to members who qualify and are living with a chronic condition. Eligible conditions include diabetes and cardiovascular disease.

If you have Prestige Health Choice patients who could benefit from complex case management, please let them know they can get referred into the program by:

- Asking their primary care provider (PCP) to refer them.
- Calling (or having their caregiver call) our Rapid Response and Outreach Team at **1-855-371-8072** (**TDD/TTY 711**) for a referral.
- Calling our 24-hour Nurse Call Line at **1-855-398-5615** (**TDD/TTY 711**). They will help to refer the member.

Also, if your Prestige Health Choice patient is in the hospital, the hospital discharge planner can refer the patient before he or she leaves.

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

Secure and confidential. You may remain anonymous.

Important reminder: **Coastal Care Services** is our home services provider

On April 1, 2018, Coastal Care Services began managing all services provided in the home with the exception of those listed below. **When rendered in place of home, these specific excluded services should be authorized by and billed to Prestige Health Choice:**

- Communication boards.
- **All** contraceptive medications and supplies.
- Cranial helmets.
- **All** end-stage renal disease (ESRD) services rendered in the home.
- Implantable device supplies (examples include supplies related to cochlear implants, permanent birth control, urogynecologic surgical mesh implants, etc.).
- Inhalation solution (solution/drug should be obtained through member's pharmacy benefit).
- OB/GYN home health services (services provided by Optum Women and Children).
  - Please contact Optum directly by phone at **1-800-999-0225** or by fax at **1-678-355-4711** before providing these services.
- Orthotics/prosthetics.
- Vision, hearing, and speech pathology services (HCPCS codes in the "V" series).

All other services not rendered in the home should be billed to Prestige Health Choice.

- For services managed by Coastal Care Services, please call their Utilization Management department for authorizations: **1-855-481-0505**.
- For services managed by Prestige Health Choice, please call our Utilization Management department for authorizations: **1-855-371-8074**.

If you have questions, please contact Provider Services at **1-800-617-5727**.

Prescription, pharmacy, and legislative **updates**

House Bill (HB) 21, signed into law by Governor Rick Scott on March 19, 2018, imposes a number of legal requirements on health care practitioners who prescribe controlled substances, particularly opioids. One requirement of the new law is that **all Drug Enforcement Administration (DEA)-registered prescribers in Florida must complete a two-hour Florida licensure board-approved continuing education course on prescribing controlled substances by January 31, 2019.** This new law encompasses 205 pages and imposes new obligations on practitioners as well as penalties for noncompliance.

HB 21 provides that a prescription for a Schedule II opioid for the treatment of acute pain may not exceed a three-day supply. Acute pain is defined as, "the normal, predicted, physiological, and time-limited response to an adverse chemical, thermal, or mechanical stimulus associated with surgery, trauma, or acute illness." These restrictions do not apply to patients suffering acute pain resulting from:

- Cancer.
- A terminal condition.
- Chronic nonmalignant pain.
- Palliative care to provide relief of symptoms related to an incurable, progressive illness or injury.
- A traumatic injury with an Injury Severity Score of 9 or greater.

The legislation does allow a seven-day supply to be prescribed if:

- More than a three-day supply is needed based on the professional judgment of the prescriber;
- The prescriber indicates "ACUTE PAIN EXCEPTION" on the prescription; and
- The prescriber documents in the medical records the acute medical condition and lack of alternative treatment options that justify deviation from the three-day supply limit.

Member Rights

Prestige Health Choice is committed to complying with all applicable requirements under federal and state law and regulations pertaining to member privacy and confidentiality rights. Please share this information with your Prestige Health Choice patients if asked. Thank you.

As a Prestige Health Choice member, you have the right to:

- Get information about:
  - Prestige Health Choice and its health care providers.
  - Your rights and responsibilities.
  - Your benefits and services.
  - The cost of health care services and any required cost sharing.
- Have Prestige Health Choice and its health care providers treat you with dignity and respect.
- Talk with your health care provider about:
  - Treatment plans.
  - Information on available treatment options and alternatives, given in a way you understand.
  - The kinds of care you can choose to meet your medical needs, regardless of cost or benefit coverage.
- Receive care that is at least equal to service offered by similar health plans.
- Receive detailed information about emergency and after-hours options. Some details include:
  - Emergency services do not require prior approval.
  - You can use any hospital for emergency care.
  - We give you lists of emergency conditions.
  - You will learn what to do after you have received emergency care.
- Be a part of decisions about your health care, including the right to refuse treatment. Your decision to do so will not negatively affect the way Prestige Health Choice, its health care providers, or the state treat you.
- Be free from any form of limitations used to discipline, for convenience, or in retaliation.
- Talk to your PCP about family planning. These services are available without prior approval. Family planning services are available from any Medicaid provider.
- Be told about free translation services. We will arrange support for any language you speak. You will be told about free services for members with vision and hearing loss. You will receive the communication services you need to help make choices about your care. We can teach you more. Please call Member Services at **1-855-355-9800** (**TTY/TDD 1-855-358-5856**).
- Access the Notice of Privacy Practices. This tells you when, why, and with whom we must sometimes share your protected health information (PHI).
- See your PHI.
- Have your privacy protected in accordance with Health Insurance Portability and Accountability Act (HIPAA) requirements.
- See a list of the people who have asked to see your PHI.
- Get a copy of your PHI in our records.
- Request a copy of your medical records and ask that your PHI be updated if it is not correct.
- Receive information about the grievance, appeal, and the Medicaid Fair Hearing process. We will arrange support for any language you speak.
- Have health care services provided in accordance with both state and federal regulations.
- Get yearly updates about the disenrollment process.
- Receive updates on major changes in your benefits. You will be notified at least 30 days in advance.
- Be given an opportunity to provide suggestions for changes to Prestige Health Choice's rights and responsibilities policy.
- Voice complaints about and/or appeal decisions made by Prestige Health Choice and its health care providers. Call Member Services at **1-855-355-9800** (**TTY/TDD 1-855-358-5856**). We will arrange support for any language you speak.

Member Responsibilities

Please share this information with your Prestige Health Choice patients. As a member of Prestige Health Choice, it is up to you to:

- Read your member handbook. Call Member Services if you have questions.
- Choose your new PCP when you get your welcome kit. Help your new PCP care for you and your family. Fill out all information sheets carefully. Help your PCP get your records from your previous doctor. Give, as much as possible, information that Prestige Health Choice needs to process claims, and information providers need to give care.
- Help your providers manage your care. Understand your health problems and take part in developing treatment goals. Follow plans and instructions for care from your providers. If your care plan does not work, tell your provider. He or she wants you to feel better. He or she will adjust your care plan to make it work.
- Keep your appointments for all regular care. Examples are child health checkups, family planning, and health screenings.
- Get a referral from your PCP before you see a specialist or out-of-network provider or go to the hospital. Only go to the hospitals or specialists your PCP recommends. If you visit an out-of-network provider, you will need prior authorization by calling **1-855-371-8074**.
- Call Member Services if your member ID card is ever lost or stolen.
- Present your member ID card any time you receive medical services from a doctor, hospital, clinic, or pharmacy.
- Call your PCP when you feel sick. Do not wait. Go to the nearest ER if you feel your life is in danger.
- Call Member Services if any information about you or your family changes, including your mailing and home address. This helps us avoid most problems. If your address has changed, please log in to your My ACCESS account and update your address. You can also contact the ACCESS Customer Call Center toll free at **1-866-762-2237**. You must also contact the Social Security Administration (SSA) toll free at **1-800-772-1213** or visit the SSA website.
- Be kind to everyone involved in your care. Be on time for your appointments. Call the doctor's office if you cannot keep your appointment.

Member responsibility for facility-based services

Member responsibility is the cost of Medicaid facility-based services not paid for by the Medicaid program and is the amount a member must contribute toward the cost of his or her care. This amount is determined by the Department of Children and Families and is based on income and type of placement. Members are required to pay patient responsibility as determined by the Department of Children and Families.

- **To file a complaint or to request more information**, call the following toll-free numbers:

  Prestige Health Choice Member Services **1-855-355-9800**, 24 hours a day, 7 days a week

  Agency for Health Care Administration (AHCA) statewide consumer telephone line **1-888-419-3456**, 8 a.m. – 6 p.m.

Direct secure messaging (DSM) enables managed care organizations and providers to securely send patient health information to many types of organizations. Prestige Health Choice encourages network providers to use DSM.

We also encourage our providers to connect to and use the Florida Health Information Exchange (HIE). HIE DSM provides health care organizations and providers with a way to send health information such as orders, records, and results securely over the internet.

To learn more about HIE and DSM, please visit the Florida HIE Services website.

If you have questions, please contact your Prestige Health Choice Provider Account Executive or call the Provider Services department at **1-800-617-5727**.

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Newsworthy and noteworthy

Electronic funds transfer is available at no cost to Prestige Health Choice providers!

Prestige Health Choice contracts with Change Healthcare to give providers the option to receive payments through electronic funds transfer (EFT).

Benefits of using EFT include:

- Prompt, easy, and secure payments.
- No need to go to the bank or use mobile deposit to deposit checks.
- Ability to view and print remittance advices online.
- Ability 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 **www.changehealthcare.com/support/customer-resources/enrollment-services/medical-hospital-eft-enrollment-forms**.

For questions, contact your Provider Network Account Executive.