Fax

www.prestigehealthchoice.com

To: Our Valued Prestige Health Choice Providers

Date: March 31, 2021

Subject: Important Update and Reminders

Below please find the latest update and reminders for Prestige Health Choice providers.

Update:

1. Prestige Health Choice entered into an agreement with Optum (f/k/a as Equian, LLC), in 2019 to review certain inpatient claims. Effective June 1, 2021, the claims submission criteria for certain inpatient claims is changing from a $50,000 threshold to a $40,000 threshold. On June 1, 2021, **Optum will begin to review all inpatient diagnosis-related group (DRG) facility claims that will pay an amount greater than $40,000 if paid as billed**. Prestige Health Choice will require that you submit an **itemized bill** with each inpatient DRG facility claim that meets this criteria. Such claims received *without* an itemized bill will be denied with denial code *EQ1 - Reimbursement exceeds $40,000, resubmit with itemized bill.* This notification **applies to and updates the Inpatient Claim Submission section, paragraph two, page 11 of our Provider Manual** at www.prestigehealthchoice.com.

Reminders:

1. Effective February 1, 2021, Prestige Health Choice established a process for submission of **interim billing for inpatient hospital stays** that exceed 100 consecutive days. Please visit www.prestigehealthchoice.com for more information on the details.
2. Prestige cannot issue payment on a claim if the **billing and servicing provider** are not enrolled with the Agency for Health Care Administration. Billing and servicing providers must both have an active record on the Provider Master List (PML).
3. Please remember to **confirm a member's eligibility** prior to rendering services.

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4. **Timely filing for claims:** Unless specified otherwise in your contract, **claims must be received within six months** of the discharge date for inpatient services, or the date of service for outpatient services. When Prestige Health Choice is the secondary payer, claims must be received within 90 days of the final determination by the primary organization.
5. **Timely filing for claim-related provider complaints:** Unless specified otherwise in your contract, **disputes must be received within 90 days** of the Remittance Advice (RA) date. To prevent delays in processing your complaint, please utilize the Provider Complaint Form located at www.prestigehealthchoice.com. For additional information regarding the Provider Complaint process, please refer to the Provider Manual located at www.prestigehealthchoice.com.
6. **Timely filing for authorization-related provider complaints:** Unless specified otherwise in your contract, providers must **utilize the Member Appeal process to dispute a denied authorization**. All appeals must contain **signed consent** from the member, and must be received **within 60 days** of the date of the Notice of Adverse Benefit Determination (NABD). For additional information regarding the Member Appeal process, please refer to the Provider Manual located at www.prestigehealthchoice.com.

If you have any questions regarding these updates, please contact your Account Executive or call Provider Services at **1-800-617-5727.**